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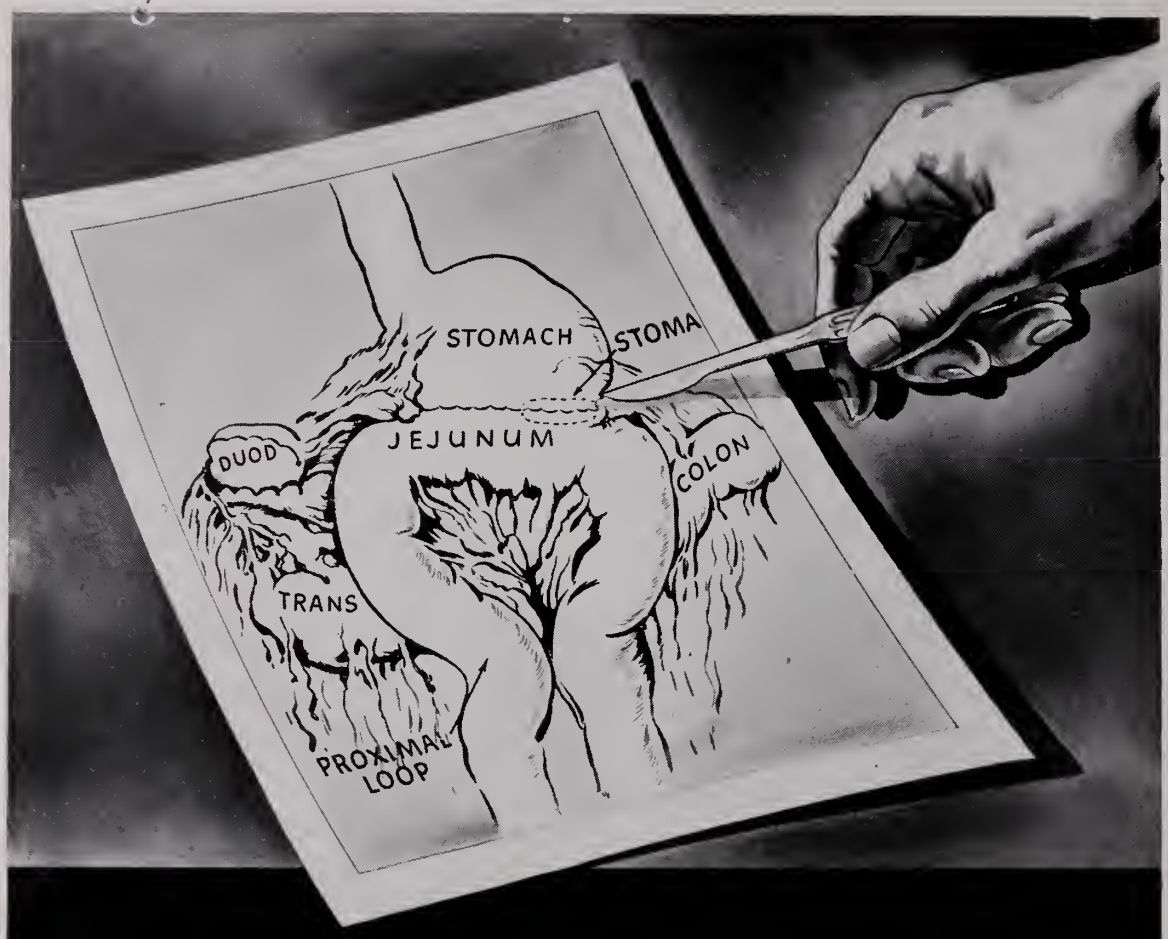
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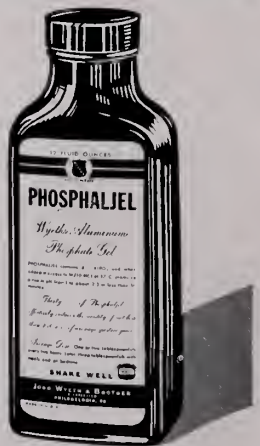
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2. FAULEY, G. B.; FREEMAN, S.; IVY, A. C.; ATKINSON, A. J., and WIGODSKY, H. S.: Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med. 67: 563-578 (March) 1941.

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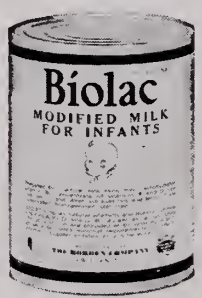
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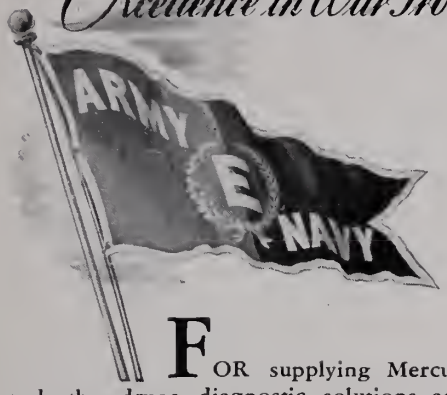
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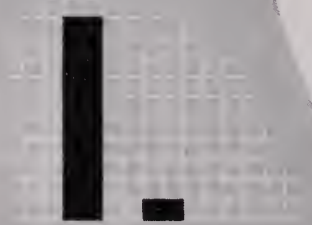
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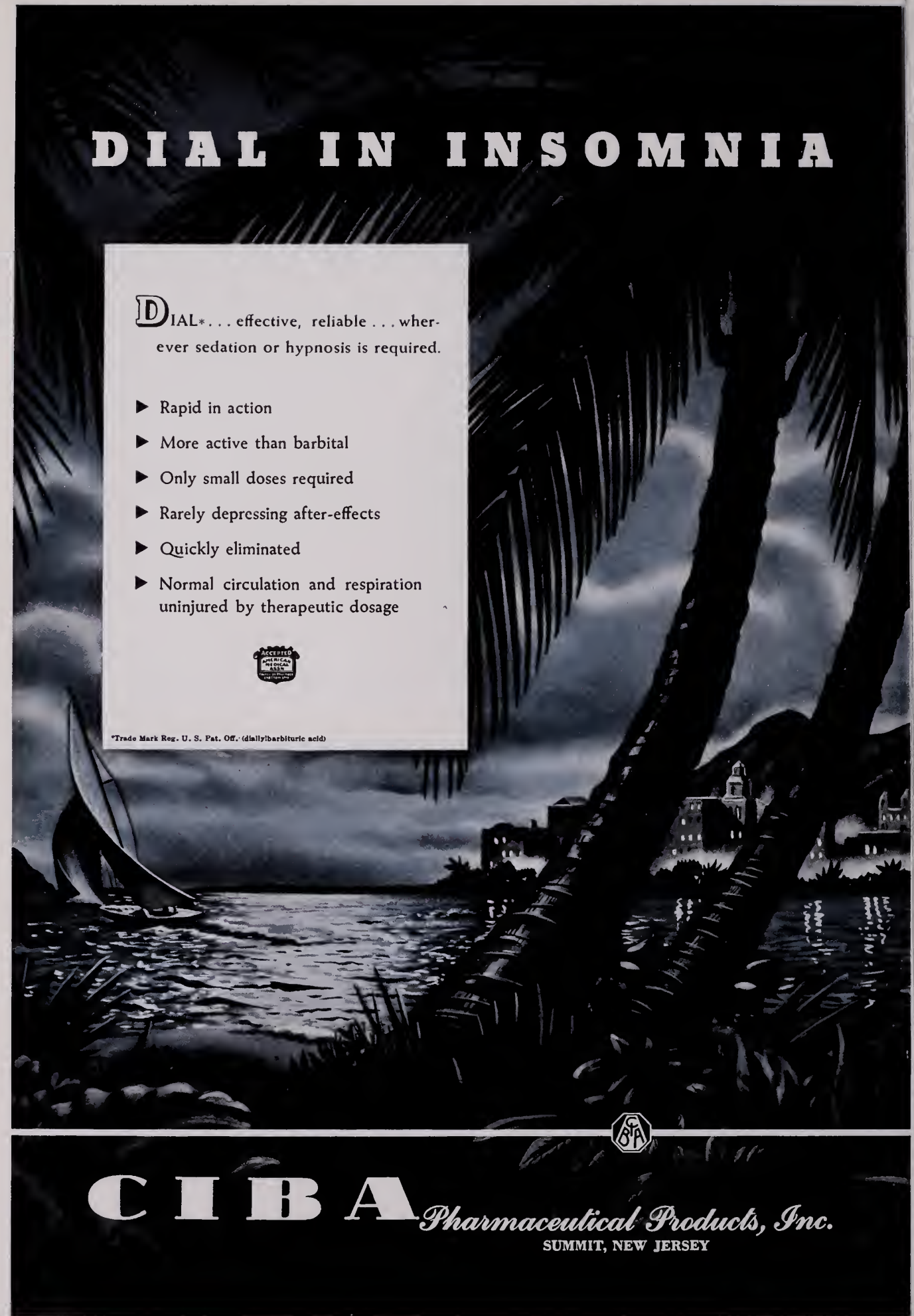
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVII JANUARY, 1944 No. 1

PLANNING FOR SECURITY*

EMERY M. PORTER, M.D.

The Author, *Emery M. Porter, M.D., President of the Providence Medical Association in 1943; Surgeon, Rhode Island Hospital; Member, Committee on Public Laws, Rhode Island Medical Society.*

As we move into another year nearer the end of the World War we find much thought being given to the various problems of post-war planning. The projects suggested for the days ahead when the guns of the world will be silenced range from the purchase of household commodities to the construction of super highways. I am struck by the fact, however, that very little sensible and constructive thought is apparently being given to the healthful life of the individual who is presumably to enjoy all these man-made benefits.

As the medical profession is the one to which the people turn for the preservation of their health, we must accept the task of initiating sound plans for making life more worthwhile for all in the post-war era. Medical procedures are predicated on careful scientific research which must be thoroughly tested and proved before general acceptance. In our approach to the solution of the economic problems resulting from illness we must be willing, with the consent of the people, to try new methods, made as sound as possible and aimed at achieving the most good for the majority. A good start has already been made in furthering prepaid voluntary insurance programs for hospitalization and for surgical care, and the expansion of the work must continue under medical supervision.

The trend of the times has been towards security, and certainly no more opportune occasion exists for such thinking than when the nations of the world are engaged in mortal combat, and all the foundations of freedom, as we have known them, are in jeopardy. In such a chaotic order of life the individual is keen to sense security in every plan, however ill-founded it may be. In our daily press and from the public rostrums, writers, politicians, speakers and social planners, many of dubious authority, have bombarded the public with emotional appeals to turn to the government for assistance in the hour of need. The constant impact of these appeals and propaganda are certain to be felt in the post-war years, and especially at such time when employment fails to provide the financial security that is so general today because of the high wages due to war expenditures.

The introduction of legislation in Congress early last summer to provide for federal hospitalization and medical care for all citizens by means of additional taxation has climaxed the security planning advanced to date. There is reason to believe that this legislation will fail of passage this year. We are forced to wonder whether the failure will stem more from those who resent the additional tax on the pay envelope or whether it will stem from the concerted effort of intelligent leaders who recognize in the legislation a final step in the invasion of State rights, and also the possible denial to the individual of his inalienable right to be master of his own life. Whatever the reason, we may confidently look for the writing of similar legislation in the years ahead, and it therefore is appropriate that we assume our rightful responsibility to solve our individual problems to the satisfaction of the people of our individual States.

The conclusions that government must assume larger responsibilities than it has carried in the past if it is to help self-supporting people to meet the problems of medical costs should be predicated entirely on the basis that the role of government should be principally to give financial and technical aid in the development of sound programs in those States that cannot financially sponsor their own plans. Too often, however, the States have seen the procedures of their own choice denied when

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*Presidential Address at the 97th Annual Meeting of the Providence Medical Association, January 3, 1944.

they accepted government grants. The present federal emergency maternity and infant care problem is the latest example of this.

Rhode Island, traditionally independent long before it took the initiative among the original colonies to declare its freedom from Old World ties, may well pioneer in any new plans for the greater health security of all its citizens. For geographic, industrial, financial and other evident reasons our State might well form a plan of its own, and at its own expense develop a sound program to guarantee a better distribution of the cost of hospital and medical care for everyone in the State and thereby set a pattern for the rest of the country to follow.

While it might be considered daring thinking to propose a union of the financial resources of the State with the voluntary agencies to meet the basic requirements of the people, the administration to remain with the voluntary groups, yet we can visualize no sounder approach to the problem whereby the freedom we so highly prize may be retained by every individual. The State, as an agency, is in a position to impose fair taxes, or to require otherwise that certain conditions must be met by the citizens. It would also appear within reason to believe that the same authority might be extended to require definite provision for medical care and hospitalization for everyone without regimenting the medical profession, or the individual citizen. The answer rests entirely in the approach to the problem—whether on the one hand, the State would be content to serve as the financial agent, and on the other, whether the medical profession and the hospitals would guarantee to assume the responsibility for providing the necessary services under their own administration.

The medical profession has always heeded the call to aid those in need of medical care, and we are confident that no person has ever been refused medical assistance in Rhode Island for lack of finances, if it were sought through proper channels. A year ago when the general public assistance act was amended it provided that the assistance granted to persons in need in the State may include necessary medical care, supplies and hospitalization. Thus the State recognized special groups of persons for whom it assumes certain public responsibilities relative to medical care without, however, placing such persons in the category of legally indigent or pauper. The difficulty ahead in administering this provision would appear to lie in the interpretation of who are the medically indigent.

According to social security proponents every illness is catastrophic in its effect upon the finances of the average family. If that is true, then the majority of people are medically indigent at some time or other; but we hardly believe that every family desires to turn to public assistance for the solution of its problem, any more than it would forfeit the privilege of purchasing life insurance to offset the family economic loss due to death, and rely entirely on State aid.

Rather do I believe that the people would prefer some way in which they may actively participate in the planning of their future, both physical and economic. The success of our system of savings banks, of private insurance of all types, of the voluntary Blue Cross hospitalization program, of voluntary agencies engaged in social work activities supported by community funds, and the acceptance of additional taxes to provide for unemployment compensation and for cash benefits for sickness indicate clearly the thinking of our people.

The danger in advancing a program to solve the greater distribution of the costs of medical and hospital care lies in the possibility of creating new agencies which may conflict with those already existing. Even now we are faced with an arrangement within our State government wherein health and affiliated programs are administered by a variety of departments with which there is little or no collaboration in the administration of their projects. For example—the State Hospitals are operated under the Social Welfare department while the State Sanatorium is under the department of health; the Cash Sickness Compensation Act is operated by the Unemployment Compensation Board; the newly planned rehabilitation program will stem from the Department of Education, while the Workmen's Compensation Division of the Labor Department operates a rehabilitation center of its own; and the Public Assistance division of the Social Welfare department offers a medical care for the needy.

Therefore, I propose that the Rhode Island Medical Society take the initiative in creating a statewide non-partisan Voluntary Council on Health which would undertake to survey the medical and health facilities and needs of the people of this State, for the purpose of recommending the coordination of present programs with any new plans whereby the medical and hospital needs of every citizen may be adequately met by the State without the utilization of federal funds.

Such a Council should, in my opinion, be composed as follows:

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PRIMARY ATYPICAL PNEUMONIA, ETIOLOGY UNKNOWN

FRANK B. CUTTS, M.D. AND HERMAN A. LAWSON, M.D.

The Authors. *Major Frank B. Cutts, MC, and Lieutenant Colonel Herman A. Lawson, MC, members of the Rhode Island Hospital Staff, now on foreign duty with the 48th Hospital Unit.*

DURING training maneuvers of the Second Army in Tennessee, we, as members of an evacuation hospital, had an opportunity to observe 60 cases of primary atypical pneumonia. There are several good descriptions of this type of pneumonia in the literature, especially the reports of Reimann (1), Smiley, Showacre, Lee and Ferris (2), Kneeland and Smetana (3), Longcope (4), and Dingle and Finland (5). Consequently no detailed description of our experience is justified. We felt, however, that a brief report, emphasizing a few features in which our group of cases differed from the usual descriptions of this disease, might be of some interest.

Almost all or our patients were young men in the 20-30 age group. Most of them were living under field and simulated combat conditions and were at times exposed to considerable cold, dampness and fatigue. The majority was received at our hospital during October 1942. During this period we saw only 3 instances of typical pneumococcic lobar pneumonia.

Symptoms

These patients were ill an average of 4 days prior to admission with the usual symptoms of malaise, headache and dry cough. A mild sore throat and mild chest pain, consisting of substernal burning or tightness, were fairly common. Two patients had marked laryngitis, and one had a moderately stiff neck which returned to normal in a few days. A definite history of antecedent upper respiratory infection was uncommon, and gastro-intestinal symptoms were rare.

Twenty-six of the 60 cases had one or more definite shaking chills early in the course or their disease. This is considerably higher than the usually described incidence of chills in this disease, the infrequency of this symptom being often mentioned (3, 5). It would seem probable that the increased fatigue and exposure to which these soldiers were subjected prior to hospitalization might well be a factor in increasing the incidence of chills beyond that observed in civilians or in troops coming to station hospitals.

Physical Examination and Laboratory Data

In general the findings on physical examination conformed closely with those described in the literature. The temperature of the patient on admission varied from normal to 104.6 F. There was usually no dyspnea, and in 29 cases physical examination of the lungs on admission was entirely negative. In the remaining 31 cases, fine or coarse rales, usually at the lung bases, were noted. One patient had a definite pleural friction rub. In most of the cases in which the lungs were clear at entry coarse rales appeared later, often after the temperature had returned to normal. These rales were usually found at the lung bases, although occasional patches occurred in other areas. In a few cases physical examination of the lungs was negative throughout the disease,—this was more likely to occur in those patients in whom the patch of consolidation observed by x-ray was small. In a few of the more severe cases dullness and bronchial breathing were observed.

In 14 patients definite herpes labialis was noted. This is worthy of some attention as many reports (3, 5, 7) comment on the rarity of this finding, and some have suggested that the presence of herpes would tend to cast doubt on the diagnosis of primary atypical pneumonia. In our cases the severity of the herpes was graded as 1-2+, using a scale of 0-4+. Perhaps its presence was also related to the increased exposure to which these soldiers were subjected, as commented upon above in connection with the incidence of shaking chills.

The white blood count was usually found to be between 8,000 and 12,000. The lowest count observed was 4,600 and the highest 33,000. As noted in other reports the higher counts usually occurred later in the disease in the more seriously ill patients.

Chest X-Rays

These conformed quite closely with those described in the literature. They usually presented the

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picture of patchy mottled dullness which often showed a tendency to extend out from the hilar region. The degree of involvement varied from a small patch, the size of a 25 cent piece, to diffuse involvement of both lungs. In 8 cases the first x-ray was negative, and pneumonic involvement was only shown by later plates. There were several x-rays with involvement of the upper lung field which were identical with those seen in some cases of tuberculosis. Only by further observation and repeated chest x-rays could tuberculosis be excluded in these patients. This point has been mentioned (6) but perhaps not sufficiently stressed, in the literature. In addition to those cases with definite lung involvement, there were many patients with border-line x-rays showing slightly increased streaking or fuzziness. These were very difficult to interpret and were not included in the series reported here.

Course

The average duration of fever after entry to the hospital was 5 days, although physical signs and cough often persisted several days longer. The cough, worse at night, was usually difficult to control. Two cases were severely ill from the onset, with dypsnea, cyanosis and a protracted course. Two patients, after a period when they appeared to be improving, had relapses and rapidly became worse with dyspnea and bubbling rales over large portions of both lungs. They received considerable symptomatic benefit from oxygen administration. One patient had had similar symptoms and pneumonia in the right lung one month previously. He entered our hospital with the typical picture of primary atypical pneumonia involving the upper portion of the left lung, — apparently a late relapse. There were no deaths.

Fourteen patients received sulfathiazole either at or before entry to our hospital. In most instances the dosage was adequate, but, as noted in the literature on this disease, there was no beneficial effect.

Epidemiology

Our data on this point are not sufficiently precise to enable us to offer more than impressions. Our 60 cases came from 37 different organizations and no more than 6 cases came from any one organization. Thus it would appear that the infection was widespread throughout the troops but that only a small portion of the personnel of any one unit was affected. During the period of this study we had 121 cases of nasopharyngitis and 56 cases of bronchitis. Until an x-ray examination of the chest was made, it was often impossible to separate these patients from those with definite pneumonia. It is our impression that many of these cases of nasopharyngitis and bronchitis represent infections with the same agent that causes primary atypical pneumonia. It would appear probable that the majority of troops in this area were exposed, but, owing to differences in the susceptibility of individuals and the virulence of the infecting agent, most escaped with no infection, some developed nasopharyngitis or bronchitis, and a relatively few developed pneumonia. Certainly the causative agent of any infectious respiratory disease associated with such a severe persistent cough must be spread far and wide.

Comment

The evidence from previous reports (2, 3) would suggest that instances of this disease first appeared in this country in significant numbers during and after 1938, although Dingle and Finland (5) believe that it was described as long ago as 1872. There is clear evidence of moderate communicability (1, 4), more than is observed with pneumococcic pneumonia. The cause is as yet unknown but considerable evidence, summarized in a recent article by Reimann (8), points to the probability of a virus etiology.

Summary

Sixty cases of primary atypical pneumonia are briefly discussed. Attention is called to the high incidence of shaking chills and herpes labialis noted in this group with a suggestion as to their possible relation to exposure and fatigue. The similarity between the x-ray picture occasionally observed in this disease and that seen in pulmonary tuberculosis is mentioned. The impression is presented that these cases of pneumonia represent only a portion of a much larger group of patients with respiratory tract disease probably caused by the same agent.

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RECENT EPIDEMIC OF POLIOMYELITIS*

EDWARD J. WEST, M.D.

The Author. *Edward J. West, M.D., Assistant Superintendent, Charles V. Chapin Hospital, Providence.*

THE recent epidemic of infantile paralysis has been the second largest in the 33-year history of the Charles V. Chapin Hospital. From June 4, when the first patient was admitted, until the last case on December 5, 172 cases were definitely diagnosed poliomyelitis at the Chapin Hospital. There were previous epidemics of this dread disease in Providence in 1910, when 102 cases were reported, and in 1916 when 134 cases were reported to our local health department, but most of these patients were not hospitalized. From 1910 to 1929 inclusive, a total of only 145 cases of poliomyelitis were admitted to the hospital, with a rather high fatality rate of 20.7%. In other words, during that time, a little more than one out of every five of the hospitalized cases so diagnosed, died.

In the summer of 1931 there was another epidemic in which 129 cases were admitted to the hospital with 10 deaths, or a fatality rate of 7.8%. There were very few cases then until 1935 when the largest epidemic in local history occurred. There were 252 cases reported in Providence, of which 127 were sent to the hospital along with 102 others from surrounding cities and towns, so that during that summer, 229 cases were treated at the Chapin Hospital with 16 deaths, or a fatality rate of 7.1%, approximately the same as in 1931.

This epidemic has not been as large as those of 1910, 1916, 1931, and 1935 in the total number of cases reported to the health department and thus becomes only the fifth largest epidemic in local history. However, this large number of hospitalized cases admitted at a time when the hospital staff had already been depleted by the national emergency, together with the increased demands in time and personnel of the new treatment, so taxed the medical and nursing staffs that the treatment and results could not have been accomplished without the help of district and health department nurses. It seems significant that practically all cases diagnosed locally in this epidemic reached the hospital. Perhaps the publicity given the Kenny treatment had a great deal to do with this fact because in the last epidemic in 1935, roughly 50% of the reported cases were treated at home.

This epidemic started with the first case on June 4. During that month there were only 2 cases, in July there were 8, in August 48, in September 75, in October 33, and in November 5, with the last case admitted December 5. This is slightly different from the two previous large epidemics which started in mid-July, rapidly increased, with the peak in the last week in August, and then gradually petered out. In the last week in August 1935, 47 cases were admitted compared to 17 this year, but where it dropped in early September this year, as it had done previously, the number of cases jumped again to a peak of 19 each for the last two weeks of September and the first week of October. That is, the peak occurred a little later and the whole epidemic lasted longer.

Of the 172 cases, 70 came from Providence and the remaining 102 from nearby cities and towns, the next largest number being from Pawtucket and Central Falls, with 26 cases. All came from Rhode Island with the exception of 16 cases from nearby Massachusetts towns, Attleboro with 8 cases being the single locality most affected. There were only 4 deaths in the 172 cases, or a fatality rate of 2.3%, which is a marked drop from the 7% of 1931 and 1935 and a far cry from the previously mentioned rate of 20.7%.

Age Incidence and Distribution

In comparing these epidemics another interesting point is the age incidence and distribution. As the name of the disease indicates, it has always been considered a disease primarily of children under 5 years of age and in 1931 our cases showed 57% to be under 5 years and 84% to be under 10 years, with only 5% in adults, or those 21 years or over. In California, in their largest epidemic in 1934, there was noted a marked shift to an older age group and we noted it in our cases the next year, to a less degree. In 1935, only 47% were under 5 years and now in this epidemic only 38% are in this

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age group. The percentage of adults in this epidemic is 7.5% as compared with the 5% in 1931 but it appears that this figure might be still higher except for the large number of young adults in the armed forces.

Another interesting point is the sex incidence. It has always been noted that males contract the disease more often than females, in the proportion of 1½ to 1. This epidemic has been no exception, with 112 males and 60 females. It seems significant that there were no males diagnosed poliomyelitis between the ages of 18 and 30, while there were 10 females. Since there were 2 male cases, age 17, who were awaiting induction in the Navy and one male, age 36, who had been medically discharged from the Army, it would seem that by law of averages, there would have been around 15 male cases in this age group instead of none.

Mortality Rate

The marked drop in the mortality rate in this epidemic is not easily explained. It must be admitted that more cases are diagnosed in each succeeding epidemic together with a great many of previously missed, mild, or abortive cases. It was perhaps not until a paper titled "Preparalytic Poliomyelitis" appeared in 1928 by Aycock and Luther that many cases were diagnosed unless there was definite weakness or paralysis. More cases were diagnosed poliomyelitis in this epidemic on definite muscle spasm and other symptoms but without the usual spinal fluid changes. However, this alone does not seem sufficient in an epidemic of this size in which there was not one death in a child. The four deaths were all adults. There were two deaths at the age of 21, both females, a male of 32 and another male of 37 years. This would give us a mortality of zero in children and 23% in adults. It would seem that in this epidemic, the disease was very serious in adults but with only 13 cases over the age of 21, the figures are perhaps too small to be significant. This has unquestionably been a comparatively mild epidemic but this fact does not seem adequate in explaining the results. There were 8 cases with primary involvement of the medulla together with 15 cases including the 4 deaths in which both the spinal cord and medulla were affected, in various degrees of severity. The fact that 19 cases with bulbar involvement were discharged well seems quite significant.

The respirator was not used in any case during the epidemic. Three of the four patients who died had not only extensive involvement of the spinal cord including muscles of respiration, but also sufficient bulbar involvement to make use of the respirator of no value. The fourth case had primary involvement of the medulla and would have been, in the past, no candidate for the respirator. There were, however, several patients with the muscles of respiration involved to some degree. Three of the cases required oxygen therapy for several days in addition to the usual frequent hot packs. The recovery of these three patients and the failure of some other cases to develop further respiratory embarrassment appeared, in the light of past experience, especially gratifying.

Contagious Aspects of Disease

Another noteworthy thing about this epidemic has been the increased number of cases in one family. We have become increasingly conscious that infantile paralysis is a contagious disease. In 1931 the disease was treated in a great many general hospitals throughout the country and in that year, in our hospital, two student nurses contracted the disease. But in 1934, a warning came from the Los Angeles General Hospital in California. They reported that a total of 137 of the medical and nursing personnel contracted the disease. Since then, contagious disease hospitals have cared for practically all poliomyelitis cases. In the epidemic of 1935 no nurses or hospital personnel contracted the disease. In the present epidemic one of the deaths was a student nurse and there was one other case in a medical student but neither had had any connection or contact with our hospital.

There were at least ten instances of multiple cases in one household. These were all brothers, or brother and sister, with the exception of one case of a father who contracted the disease three weeks after his son, a mother who contracted the disease following her son, and the third, an aunt living in the same house with two nephews, both of whom had had the disease. In still another case, a boy was admitted with primary bulbar involvement following the death of his brother a few days before. Another thing notable in this epidemic was the appearance of infantile paralysis in three pregnant women. The high incidence of poliomyelitis in pregnancy has been noted previously many times but three cases in a total of 10 females of childbearing age is undoubtedly all out of proportion to the incidence in the general population.

Poliomyelitis has no doubt always existed but medically it is comparatively young and it seems to be on the increase. The disease was first noted in an epidemic in England in 1835. In 1840, Jacob Heine, a German orthopedic man, first described

the disease clearly and in 1890, Medin in Sweden distinguished different types of the disease and also reported that the disease occurred both in endemic and epidemic form. For some time following these revolutionary papers, the disease was called Heine-Medin's disease, or infantile paralysis. The first case ever reported in Providence was in 1895 and there were, until the epidemic of 1910, only 14 cases ever reported in this locality.

The cause of the disease is now very definitely known to be a filterable virus which is present in the nose and throat and also the stools of active and convalescent cases, as well as in the so-called contacts or abortive cases. Considerable experimental work with the virus has been done with monkeys, and because the disease was only successfully inoculated through the nasal passages, the nasopharynx was accepted almost universally as the portal of entry as well as the portal of exit of the poliomyelitis virus. Various proofs were offered by cutting the olfactory bulbs and cauterizing the nasal mucosa which prevented the disease in these animals. On the basis of this data, cauterizing the nasal passage with various chemicals was carried out in previous epidemics.

More recently, however, evidence has been accumulating to show that not only is the virus found in the stools of patients and so-called abortive cases, but it is also found very much easier than in the nose, and found in tremendous quantities, even for months after the initial infection.

Discussion of Diagnosis

The diagnosis of infantile paralysis can be very simple or quite difficult depending upon the extent of the disease. We now recognize that the disease is present at times without clinical symptoms, the so-called abortive or non-paralytic type. Then there is every gradation up to the extensively paralyzed case. In the clear-cut case, in the majority of patients, there are signs of a mild upper respiratory infection, invariably a slight sore throat and fever. About the second or third day after this apparent invasive period, symptoms of headache, fever, irritability, vomiting, pain, and muscle spasm in the neck and back, and sometimes in the extremities, appear.

The physical findings in the average clear-cut case are quite characteristic. The patient lies quietly, usually does not appear sick, but does not want to be disturbed. The neck is moderately stiff or spastic when the head is flexed on the chest, and the patient complains of pain in the spine or lower back. On sitting up, the patient will hold his back rigid and support himself with both hands.

The spinal fluid by this time shows characteristic changes and on lumbar puncture the fluid will show a positive Pandy reaction together with a cell count usually in the hundreds, together with other normal factors which rule out other meningeal diseases.

All hope of prevention or control of this disease has met with little or no success. The use of immune blood or convalescent serum first advocated by Dr. Aycock in Massachusetts in 1927, and widely used in the 1931 epidemic, has now been entirely discarded as useless. Dr. Aycock himself says that he should be the last to give up all hope in it but that he has for the past several years.

Vaccines were extensively used in 1935. Vaccination with a chemically attenuated virus was advocated by Kolmer but has since been discarded as potentially dangerous. Another vaccine, that of a completely inactivated or dead virus, advocated by Park and Brodie in New York, has also been discarded as of no value. Both these methods were condemned by the U. S. Public Health Service.

The cauterization of the nasal passages with chemical agents such as alum, picric acid, and zinc sulfate has not been found practical in the general population. Furthermore, the theory of the entrance of the virus through the gastrointestinal tract makes this method appear of only doubtful value.

With no effective method of control of the disease and no known specific treatment in the acute stage, it is no wonder that a potential epidemic of poliomyelitis has always caused a certain sense of helplessness. The wide publicity, the numerous medical articles, and the more or less general acceptance of the Kenny concept of the treatment of infantile paralysis have offered some hope of treatment of the disease in the acute stage and it was decided early to carry out this treatment as near as that outlined by Sister Kenny as possible.

PRIMARY ATYPICAL PNEUMONIA

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KENNY TREATMENT OF POLIOMYELITIS*

WILLIAM A. HORAN, M.D.

The Author, *William A. Horan, M.D., Medical Director, Division of Crippled Children, Rhode Island State Department of Health.*

IT IS my purpose to review the Sister Kenny Treatment of Infantile Paraylsis which we gave to patients in our State during the Summer of 1943, with the purpose of stimulating constructive criticism which can be used to further this treatment. Probably the best way to give you the facts concerning the epidemic is to divulge them as they occurred and in the order in which they presented themselves. The first thing of note that comes to my attention is the anxiety evidenced by the authorities at the Chapin Hospital as to the probability of an epidemic. This anxiety was stimulated by the watchfulness of Dr. Gregory over charts and statistics, and the appearances of cases of polio in our neighboring States and immediate vicinity. On his insistence that an epdemic was in the offing, the State, through the agency of Dr. Edward McLaughlin, head of the Health Department, laid plans to take care of the emergency. Public acclaim dictated that these plans be made to embrace the Sister Kenny treatment. Before they could be put into operation, Dr. William Hindle, Superintendent of the Chapin Hospital, informed us that his nursing personnel was so depleted by the war effort that he was finding it difficult to give the additional service which the Sister Kenny treatment required to the slowly increasing number of polio cases in the Institution.

I do not believe that any of us, at the beginning of the epidemic, were cognizant of the tremendous amount of laborious work connected with the successful application of this method of treatments.

Work of Nurses Heroic

Fortunately for us the Providence District Nursing Association, under the able administration of Miss Dillon, loaned to the Hospital twelve able staff nurses. Also two nurses from the Providence Health Department were loaned us by Dr. Michael J. Nestor, Superintendent of Health. Two of these nurses were sent to New York each week, where they received a seven day course in the application of hot packs, their training arranged for by Mrs. Catherine Tracy, Director of Public Health Nursing in the State Department of Health. This training was paid for by the Infantile Paralysis Foundation on the recommendation of Dr. McLaughlin. As the admissions at the hospital increased, it was necessary that two additional trained workers be provided each week to augment the nursing staff of the hospital trained by Miss Cahalan, the assistant director of nurses, who was already trained in this work. Nothing can be said, no matter how laudable, which would sufficiently praise the work of these nurses whose work was to combat one of the most important causes of deformity — MUSCLE SPASM.

The extraordinary magnitude of this task cannot be appreciated unless seen. One can picture its greatness when I say that at the height of the epidemic more than 100 children, in addition to ordinary hospital care, received four to six packs a day, most of which included the neck, back and lower extremities. Not only was it necessary for the nurses to apply the packs but they had to remove them and place them in a container to be ready for another application. In spite of the greatness of the task, order prevailed throughout the Institution. Teams divided the work and everything ran with clockwork precision.

The girls evidenced such interest in their work they would not appreciate fatigue. One girl worked so hard at the head of her team that she did not realize the toll this work took from her personal health. When she was relieved, her personal physician told me that her one desire was to see the job through. When questioned concerning her interest she claimed that she had never been associated with any treatment which gave such immediate and satisfying results.

This hot pack treatment is carried out after the patient has been placed on a blanketed mattress stiffened by a board placed over the springs, with the mattress pulled back from a footboard for a

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distance of four inches so that the soles of the patient's feet rest against the footboard and the heels are in the space provided by the shortened mattress. The position assumed is as near the standing pose as can be accomplished. This position is changed according to the severity of the symptoms. The footboard is to stimulate reflexes and not to splint the feet. Up to this time we were concerned with the immediate relief of muscle spasm. While the hot-pack girl is indispensable in this phase of the work, Sister Kenny believes it necessary to retain and stimulate muscle awareness. This work falls into the field of the physical therapists.

Role of Physical Therapists

The Pawtucket Visiting Nurses Association graciously loaned Miss Johnson, their physical therapist, trained in the Kenny method, and the Memorial Hospital loaned us their Miss Cogan. The Infantile Paralysis Foundation sent Miss Babcock, from the Crippled Childrens division, Miss Ahern, loaned from St. Joseph's hospital, Miss McVey from the Rhode Island hospital, and three nurses from the Health Units loaned by Dr. Corrigan, to the University of Pittsburgh for training. Fortunately, the physical therapists completed their course in one month and were back in time so that we could utilize their knowledge before the epidemic reached its height. Their job, while probably not as laborious as that of the hotpack nurses, was far more tedious. It was primarily directed toward decreasing the incidents of inco-ordination, the second major symptom of infantile paralysis according to Sister Kenny, and in giving muscle stimulation to this suffering from mental alienation (those muscles which have become dissociated from the nervous system and appear paralyzed.) This work requires an unusual knowledge of anatomy, patience and persistence on the part of the operator.

Briefly, it is based on the theory that the joints and tendons have proprioceptor receptors which transmit impulses along afferent nerves to the spinal cord, then to the subconscious, finally to the conscious mind. Since an alienated muscle is usually caused by spasm in its opponent, great care is needed by the physiotherapist not to stimulate further spasm and to retard progress in the alienated muscle. This is particularly true since the muscle stimulation must be started early in the disease, frequently before muscle spasm has entirely subsided. We were particularly fortunate in having with us in this treatment girls who were exceptionally well trained in the Sister Kenny method and who had a good background in anatomy.

In some instances it was necessary to give the patients muscle stimulation daily. Nine of these girls had all they could do to keep up with the program. In fact, it was necessary, during the height of the epidemic to require them to do as many as 16 cases each, daily, in place of the recognized 8 to 10 cases.

Many incidents had to be taken care of as they arose. One of these pertain to the daily treatment by the physical therapist. We felt, and they felt, that the patients needed the attention just as much on Sunday and holidays as on other days. We also appreciated the unfairness of having them work without recompense. The Infantile Paralysis Foundation stepped in again and made a satisfactory arrangement through which the patients received their daily treatment.

Another incident was caused by the Dick Tracy and Superman and various other comic strip characters. As I have said, it was necessary for patients to lie with their feet against a footboard. One day making rounds I found that someone with good intentions had distributed a comic book to each and every child. Instead of lying on their backs quietly and reading the books as the donor had envisioned, the children were in all sorts of positions, contrary to their well-being. Needless to say the books were removed.

Summary of Cases

Altogether 173 cases were admitted to Chapin Hospital, and 4 were hospitalized at St. Josephs'. Of these 177 cases, 83 had muscular involvement, 94 cases had spasm of the neck, back and hamstrings without any definite muscular involvement. In all of these cases muscle spasm could be demonstrated in the back and hamstring muscles. Of the 87 cases of muscular involvement, an attempt was made to separate the mentally alienated from what was thought to be definitely paralyzed cases. There were 35 of the latter divided as follows:

Spine	1
Upper Extremity	9
Lower Extremity	25

The mentally alienated cases were:

Neck	1
Spine	2
Upper Extremity	22
Lower Extremity	58

Before a patient was discharged from the hospital, the mother or a responsible relative was brought to the hospital and given a course designed to teach them how to apply hot packs at home. These

continued on next page

individuals were of great assistance to the hospital while taking the course and also in the follow-up care of the patients at home.

The average case with simply muscle spasm was discharged in four weeks to continue his hot packs at home under the supervision of the physical therapist. Those having muscle involvement were kept for a minimum of six weeks, depending upon the severity of the case. I wish to emphasize the fact that the Kenny Treatment requires much more work than the orthodox or old treatment. In this treatment where splints and casts were applied one nurse could easily take care of 5 to 10 patients. As I have tried to illustrate, the Kenny Method requires 4 to 5 nurses to look after one patient. The expense, of course, is accordingly greater in the Sister Kenny treatment than in the orthodox treatment.

As yet it is too soon to evaluate the treatment but I think I can safely say it is well received by the patients who are made more comfortable by its application. Just what the end result will be, only time can tell.

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PLANNING FOR SECURITY

continued from page 10

Five members of the Rhode Island Medical Society, to consist of the President of the Society, who shall act as chairman of the Council, the President of the Providence Medical Association, and three members at large to be appointed by the President of the Society.

The executive secretary of the Rhode Island Medical Society who would serve as secretary of the Voluntary Council on Health.

Eight representatives of the public, of whom there shall be at least one who is a citizen residing in and representative of Bristol County, of Kent County, of Newport County, and of Washington County.

Two representatives of industry.

Two representatives of organized labor.

One representative, who shall be the official head or an accredited official of each of the following:

The Rhode Island Bar Association
The Rhode Island State Dental Society
The Rhode Island Nurses' Association
The Rhode Island Hospital Association
The Rhode Island State Department of Health
The Rhode Island State Department of Social Welfare
The Rhode Island Conference of Social Work

Unless otherwise indicated, all members of this Voluntary Council on Health would be appointed by the President of the Rhode Island Medical Society, with the consent of the Council of that Society.

The Voluntary Council on Health would be invited to meet as a Conference at the invitation of the Rhode Island Medical Society as often as is advisable. The Council would be delegated to make public its findings, and to seek the fulfilment of its programs by whatever methods are proper and deemed most advantageous to the public.

In proposing this idea for a statewide Voluntary Council on Health I express the hope that it would go far beyond the stage of a mere advisory group, of which we already have too many that fail to function effectively in aiding our State-administered programs. I would look to this Council to initiate, with the support of the medical profession, a definite program to further the hospital, medical and health care of all the citizens of Rhode Island, taking full advantage of existing agencies and continuing within the social patterns that are most acceptable to the people of Rhode Island.

COMPULSORY HOSPITALIZATION INSURANCE PROPOSAL

(Excerpts from the address to the General Assembly of Rhode Island on January 4, 1944, by Governor J. Howard McGrath)

Perhaps this great country would not yet have embarked upon a broad program of social legislation if the initiative were not taken by the Federal government in the depths of the depression. For that initiative and for all the good that it has produced, we are mindful and grateful, as we have been co-operative.

We believe, however, that many of these programs could be better operated by the States where the details of the system could be efficiently integrated to the economy and needs of local conditions.

I believe the time may be appropriate for our State to petition for a return to state control of administration of the Unemployment Compensation program. We may have to urge this step strenuously if the constant threat of federalization and absorption of our trust fund for Unemployment Compensation continues. In any event, we must begin to think ahead of the Federal government with respect to future social security programs, or stop talking about State's rights.

Apropos of this belief which I have expressed on several public occasions I have tried to stimulate thinking and study and co-operation in Rhode Island, to the end that we might organize our own programs. I asked the Department of Social Welfare some months ago to give serious consideration to a program that would better secure the health of our people so that we could get away from one of the great causes that lead people eventually to public assistance rolls.

By these studies, which are continuing, we conclude that serious illness in a family resulting in heavy hospital costs is one of the major threats to the security and economic well being of the people.

Your far-seeing wisdom of establishing a Cash Sickness Insurance Law for Rhode Island only partially meets this threat. Cash Sickness Insurance gives the worker absent from employment through illness, compensation for the loss of wages but out of that compensation he must meet the continuing cost of living. Here again, Rhode Island did not wait for the Federal government to take the initiative and her action underscored our belief that along with the principle of State's rights goes the burden of State responsibility to meet these social problems.

Leaders in the field of medicine, hospitalization, persons interested in hospital insurance and many other civic minded citizens have taken part in our inquiries with respect to the question of adequate hospitalization at minimum costs for our citizens. The study has commenced and proceeds upon the broad principles which I hope may be the foundation of future social security programs. I might outline those principles broadly as follows:

(1) Utilization of existing facilities wherever possible, always avoiding the expense incident to the creation of new and duplicating facilities.

(2) Compliance with the principles and practices of the professions or institutions to be affected by a proffered program.

(3) Coverage in any program devised for as many people as possibly can be included.

(4) Encouragement of the participants in a program which usually means industry and the worker to assume and share together financial responsibility for a program with a minimum state participation.

(5) Avoidance of Federal or State domination and control of programs and the utilization of the organization and facilities of the institutions most affected by the program.

We have proceeded on the assumption that government encouragement and sympathy for a program need not imply all-out governmental administrative control. With these thoughts in mind I have asked those who have been studying a program of general hospitalization insurance to present an outline of a workable program that you might consider for adoption. One that would assure hospitalization to every employed worker and his immediate dependents. Such hospitalization should include meals and dietary service, general nursing care, operating room as needed, ordinary medicines and dressings, laboratory examinations, oxygen and serum, physical therapy, maternity care, emergency care and mental and tubercular care.

These services could be provided on an employer-employee contributing basis. A simplified quarterly

continued on next page

contribution of fixed amounts would avoid difficulties now experienced in plans based upon percentage deductions each week. They can be had through the Blue Cross, or any other authorized insurance company, willing to insure for these minimum benefits and for a stated number of days.

It is our belief based upon present studies that this assurance of hospitalization to himself and his dependents could be had for perhaps less than five cents per employed person per day.

I am sure we must agree that if such benefits could be provided at this small cost, great dividends would be returned in the health of our people, in their economic usefulness to industry, and in a lessening of the causes that I have said lead to permanent disability and public dependency.

Hospital facilities at the present time are filled to capacity. It is obvious that additional facilities are needed. I have talked with some representatives of voluntary Rhode Island Hospitals. I have been encouraged by their response. I believe that if the hospitals of Rhode Island had the assurance that every patient requiring their services was an insured patient, they would be only too willling to build their facilities to meet our requirements.

It is not the original outlay for facilities that concerns the hospitals, but rather the ability of its patients to contribute to maintenance costs after construction is complete. A compulsory hospitalization insurance law would give to Rhode Island hospitals a measure of financial stability they have never before enjoyed. The date of actual operation of such a plan would depend upon the time when such increased facilities would be available. The hospitals cannot begin to plan these facilities until they have the assurance that they can at least be made self-supporting.

I believe the passage of a Compulsory Hospitalization Insurance Law at this session would give that assurance, and that the construction work that would be induced thereby would be a great boon to the business of the State in the immediate postwar period.

If the State, our voluntary hospitals, the medical profession (and in this respect let me say that the medical profession, alone should be the judge of the need of a person for hospitalization) join with labor and with industry in exercising vision, energy and determination to achieve the broad purpose of such a program, and attempt to reach a satisfactory formula for effecting it, we will eliminate the need or the dangers of a Federal program in this field.

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PHYSICIANS AND DENTISTS

With this issue a dental section is added, and the JOURNAL thereby becomes the official publication also of the Rhode Island State Dental Society. This action, approved by the Publication Committee of the JOURNAL, marks the first instance, to our knowledge, in the country where a state medical journal has also extended its service to the closely allied profession of dentistry.

To many outside our State this action might require detailed explanation. But to physicians and dentists who have labored side by side in the promotion of health for the citizens of Rhode Island through many years, the opening of the pages of the official publication of the State Medical Society to the closely allied profession of dentistry is the climax of a natural development.

It was a graduate of Jefferson Medical College in 1827, Samuel Sheldon Fitch, who is frequently referred to as the father of American Dentistry, probably due in some measure to his book of observations on the importance of teeth. In 1840 the Baltimore College of Dental Surgery was founded, and five years later the second dental school in the world was organized in Cincinnati by physicians, some of whom were practicing dentistry. Today most dental schools offer instruction in medical subjects, and significant of the trend was the action taken three years ago by the Harvard Dental School in voting a five year course which would graduate students with the combined title of M.D. and D.M.D.

Relations between medicine and dentistry have always been most cordial in Rhode Island. The late Dr. Charles F. Gormly, who was signally honored by the State Dental Society a year ago this month, was a dynamic force in fostering an affiliation between the two professions, and the inclusion of a dental section in the MEDICAL JOURNAL was a hope he long cherished.

Among the major weaknesses reported of dentistry in New England is the absence of a publication issued frequently enough to have any timely value. If the MEDICAL JOURNAL may now in some measure remedy that situation for the dentists of Rhode Island, and if through the medium of its columns it may strengthen the medical and dental organizations for combined action for the support of better health for all of the citizens of the State, it will have made significant contribution to the Professions it now serves.

COMPULSORY HOSPITALIZATION

The proposal of Governor J. Howard McGrath in his address to the General Assembly for a compulsory hospitalization program for Rhode Island indicates forward thinking on a problem that has already been publicized widely by federal social security planners. We commend Governor McGrath for his initiative in this manner, and for his evident desire to uphold State's rights.

We take exception to his statement, however, that "the passage of a Compulsory Hospitalization Insurance Law at this session would give that assurance, (that the hospitals would be self-supporting) and that the construction work that would be induced thereby would be a great boon to the business of the State in the immediate postwar period."

There should be no attempt to hasten legislation on this program for the Assembly to pass upon at this session. At its earliest the proposed program could not be put into operation until years hence, and even if the hospitals had assurance today of financial support for the maintenance of additional facilities they would require a year at least to draft construction plans, to say nothing of looking ahead to the problem of priorities in materials and labor. And how great a boon to the business of the State such construction would be in the light of other postwar construction plans already reported by federal and state authorities and private industry is debatable, and certainly should not be utilized as an offering to labor to support any legislation immediately drafted.

A program as involved and as vital to the welfare of the citizens of the state as the proposed hospital insurance plan will require careful study and scrutiny by all those who will be called upon to render the services proffered, and by all those will be the beneficiaries. We can think of no finer approach than that suggested by Dr. Emery M. Porter in his presidential address to the Providence Medical Association. A statewide non-partisan Voluntary Council on Health, such as he recommends, might well shape the plan upon which proper legislation would be subsequently drafted in a manner agreeable to all concerned.

It is to be regretted that the Governor's proposal has already been construed by some persons as health insurance. It is hardly that. While the environment and the facilities of the hospital are undoubtedly contributing factors towards recovery from serious illness or injury, they are necessarily only part of medical and surgical care. As a means of easing the major cost of hospitalization for the individual, and at the same time guaranteeing that the hospital will be better able to maintain operating costs, this proposal for compulsory insurance is mainly one of economics.

However, in the consideration of the entire plan there are many factors which are not readily apparent at first reading, and detailed study and evaluation of them is necessary before the final program is drafted and legislation is enacted. With no intention of provoking discussion at this time, but rather as evidence of the complexity of the problem, to us at least, we make the following observations to indicate the need for comprehensive community thinking and planning on this latest proposal for security in Rhode Island.

First we note the point that our hospitals are now overcrowded. That is very true at the present time, due to many factors, not the least of which has been the trend in the past decade to accept hospitalization with less fear than was once attached to it. The expansion of voluntary plans has given impetus to the greater use of hospitals, and undoubtedly a compulsory hospital insurance program would eventually tax the accommodations to be created under the expansion of present facilities.

Again, the Governor has indicated that the date of actual operation of the plan would depend upon the time when the increased facilities would be available. This prompts us to wonder if hospitals would build additional structures merely on the strength of a statute that could be amended or nullified by future legislative action. Or would they prefer to accept grants from the public funds, as the Chapin Hospital now receives from the State, and the various hospitals of the city receive from Providence, to aid in maintaining their financial stability, with no interference in their administrative procedures by either the State or the City?

We must consider also the fact that the members of the armed forces will undoubtedly receive all the benefits of hospitalization that have been accorded to veterans of previous wars. The creation of additional Veterans' Facilities will result from the transfer of the many Army general hospitals, of permanent structure, now used for both war casualties and the sick and injured men still in for training. This hospital service, if extended also to the dependents of men in the armed forces, will automatically absorb many hospital cases in the years ahead.

Secondly we are reminded that the person who requires hospitalization requires medical attention. We noted with interest, but with some misunderstanding as to why the remark was parenthetical, that the Governor stated in his address that the medical profession alone should be the judge of the need of a person for hospitalization. We are sure all agree on this statement. However, the doctor's relations with the hospital extend far beyond mere certification for the admission of patients. For him the proposal evokes many questions that escape the layman. Will there be medical and surgical men to staff the increased facilities? Will medicine become centralized about the hospital with limitation of home visits? Will present staff regulations, made to guarantee high standards of service, be altered, even to the extent of providing for "open staffs"? Would the plan provide for ward care with the result that the patient would be denied his private physician and be under free hospital service?

Thirdly, we must be concerned with the care of all of our people, and, as the Governor has stated, we must get away from the causes that lead people eventually to public assistance rolls. Yet if hospitalization is to be secured only by quarterly payments while a person is employed, the desire for a long term contract will be discouraged, and the unemployed individual will immediately become a person in need who may be declared eligible for hospital care under the amended public assistance act. We must be extremely careful in all our plans not to destroy the initiative and the desire on the part of the individual to participate voluntarily in the safeguarding of his own future, both for his own good, and that he may not become a liability to the community.

Fourthly, we are of the opinion that in maintaining State's rights, and in defining the responsibility of the individual relative to his own protection, we must also take cognizance of the freedom of private enterprise. Our Governor has wisely laid down as a principle for any hospitalization plan that existing facilities should be utilized wherever possible, and that insurance under a proposed plan may be had through Blue Cross or any other insurance company. Care must be taken in any planning to consider the relative positions of non-profit and profit-making agencies already serving the community.

Undoubtedly many thousands of our citizens have purchased private insurance contracts to provide hospitalization and additional benefits to include even payments for medical care. We must be certain that these contracts are not placed in jeopardy, nor the private insurance companies denied in their public service by any uniform hospitalization agreement created by statutory regulation.

As we have already stated, we do not list these observation as objections, but rather as pertinent issues that are undoubtedly but a few of the many that might be posed upon a detailed study of the Governor's proposal. We are sure that the medical profession will not only be ready, but anxious to contribute to the fulfillment of any program affecting the hospitalization of the people of Rhode Island. We look to the adoption of Dr. Porter's splendid suggestion by the House of Delegates this month, and the subsequent thoughtful study of this and other current problems by the statewide Voluntary Health Council.

MIDWINTER MEETING

The continuation of the procedure adopted two years ago whereby the Society joins with the Providence Medical Association to hold a combined midwinter meeting in February will merit wide approval. Every doctor recognizes the importance of scientific sessions to further his knowledge in the newest medical and surgical procedures, and yet he is faced with so many demands on his time he often must deny himself the pleasure of attending meetings at this season of the year.

As the Providence Association meets regularly on the first Monday of each month the joint meeting on February 7th offers an opportunity to the majority of the physicians of the State to support both societies, and also to participate in what promises to be an outstanding scientific program. The decision to have a panel discussion on "Respiratory Diseases" is most timely, and the exploration of the topic can be of inestimable value to every doctor. Check the date now—Monday, February 7th, at 8:30 P. M.

NEW ENGLAND MEDICAL COUNCIL

The statement of the six New England Medical societies, following a study by their appointed representatives, on the Wagner-Murray-Dingell Act indicated again the importance of joint discussion on mutual problems by the medical profession of the Northeast. Therefore we note with interest and pleasure that Dr. Michael H. Sullivan, President of the Rhode Island Medical Society, has taken the initiative in exploring the possibility of a Council of the Medical Societies of New England, and we sincerely hope that the proposal he has already made to the Presidents of the other state medical organ-

izations in this area will strike a responsive chord.

Recognizing that each Society has problems peculiarly its own which cannot be solved by any general provision, the Council would serve as a body to deliberate upon those larger matters in which each is equally concerned. In view of the fact that each Society is a component unit of the American Medical Association, this Council would not seek to supersede the control now exercised on organized medicine by the House of Delegates of the national organization.

Rather it would consider any problem submitted by a member Society, or its representative, which would in any manner affect organized medicine or public health in the New England States, or in any one of them. The Council would also serve as a body to initiate studies on problems of mutual interest to the member Societies. For example plans and programs for voluntary medical care, group hospitalization expansion, postgraduate medical education, public relations relative to the problems of organized medicine, participation in federal-state programs, national and local health legislation, development of medical journals, and the assignment of dates and the arrangement of exhibits for medical meetings might well come within the purview of the Council.

The Council as tentatively proposed by Dr. Sullivan would be composed of the Presidents of the constituent State Societies and of two additional representatives who shall be appointed by the President, or the governing body of the respective State Society as it shall determine, each to serve for stated terms.

Meetings would be held in September and April of each year, and at such other times as the necessity arises, at times and places designated by the President of the Council.

The expenses of the Council organization would be prorated annually among the six State Medical Societies.

KEEP WELL CRUSADE

The "Keep Well Crusade" launched this month by the health division of the Civilian War Services Branch of the State Council of Defense in cooperation with the State Medical Society is an outstanding example of public relations at a time when the medical profession of the State is faced with multitudinous obligations over and beyond the ordinary call of ordinary duty that are not generally known to the public.

In spite of the fact that the withdrawal of physicians from the State has automatically limited civilian medical service to the extent of the physical ability of the civilian doctors to meet the demands, most persons have not been too conscious of the seriousness of the problem until recently. The release, therefore of the excellent leaflet giving advice on the conservation of the busy doctor's time, and offering suggestions to the individual relative to the protection of his good health, is not only timely, but also an outstanding contribution to the war effort.

Distribution of this leaflet by the Civilian War Services branch to place it in every home in the State this month by volunteer workers constitutes a sizable task. To the State Defense Council which has sponsored the "Keep Well Crusade", and particularly to those representatives of the Society, Drs. Joseph C. O'Connell, Elihu S. Wing, and Charles J. Ashworth, who have contributed in such large measure to the development of this particular program, we are all indebted.

LIBRARY ADDITIONS

The Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:—

LABORATORY DIAGNOSIS

James C. Todd & Arthur H. Sanford—Clinical Diagnosis by Laboratory Methods. A Working Manual of Clinical Pathology. 10th ed. Phil., 1943.

MEDICINE

Russell L. Cecil, editor—A Textbook of Medicine, by American authors. 6th ed. Phil., 1943.

NERVOUS SYSTEM

Ernest Gellhorn—Autonomic Regulations. Their Significance for Physiology, Psychology and Neuropsychiatry. N. Y., 1943.

Stephen W. Ranson—The Anatomy of the Nervous System from the Standpoint of Development and Function. 7th ed. Phil., 1943.

ORTHOPEDICS

Orthopedic Subjects. Military Surgical Manuals, vol. IV. Prepared and edited by the Subcommittee on Orthopedic Surgery of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Phil., 1942.

PEDIATRICS

L. Emmett Holt—Care and Feeding of Children. Revised and Enlarged by L. Emmett Holt, Jr. N. Y., 1943.

RHODE ISLAND STATE DENTAL SOCIETY

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A DENTAL JOURNAL

On that day eons and eons ago when primitive man first scrawled crude drawings on the walls of his cave depicting his domestic life and surroundings, he climbed several rungs higher on the ladder of civilization. Whether these feeble attempts at art were intended to satisfy an inner urge to express himself purely for Art's sake or whether we may attribute these sketches to idle "doodling" to while away the time while awaiting the opening of the pterodactyl hunting season, consciously or unconsciously, he left man's first written record for posterity. Ever since that day man has attempted to express in writing his thoughts and ideas that he might convey these to others or merely as a matter of record. In either event these transient soon-to-be-forgotten thoughts are arrested from the evanescent present and are transfixed as a permanent record so that countless other eyes of this and future generations may read, reflect, and compare his findings with theirs. Only in this way can man really make progress, for unless he can profit by the recorded mistakes and findings of his predecessors, his whole life will be spent in retracing the same culs-de-sac already searched by those investigators who preceded him.

The founders of the Rhode Island State Dental Society or its progenitor must surely have thought these selfsame thoughts in drawing up the society's constitution, for in their wisdom they created the office of Editor despite the fact that until to-day the individual who was elected to and held that office was merely a figurehead.

The publication of a Journal of the Rhode Island State Dental Society is a matter which has received serious consideration from the officers and Board of .Trustees of the society for several years After careful study of the problem, however, the expense of such a publication, which would have to be borne by the relatively small membership of our society, was deemed a prime consideration and the undertaking did not seem feasible. Therefore, when the Rhode Island Medical Society recently very graciously extended an invitation to the Rhode Island State Dental Society to participate in the publication of its own very fine journal, our dream of several years seemed about to be realized. Not only would the Rhode Island State Dental Society have an official Bulletin, but such close and friendly collaboration between the members of the medical and dental professions in this state is in itself highly desirable.

So in a year of world conflict with our active roster considerably dwindled, we hope and pray, by only temporary absence of a number of our brothers in the armed services, the state dental society of the smallest state in the Union holds high the torch of organized dentistry and makes a great stride forward. With this issue of the Rhode Island Medical Journal the Rhode Island State Dental Society makes its debut on the printed page. In that section of the Journal devoted to Industrial Health will be found a paper written by one of our own members, the first, we hope, of many to follow.

With this issue also your editor dips his pen into ink for a few brief moments and then passes it on, scarcely dry, to his successor.

ANNUAL MEETING

The 66th annual meeting of the Society to be held this month takes on added significance in view of the fact that it is being held in spite of the many war restrictions. We have lost many members from the State to the armed forces, and therefore there is a corresponding obligation for all our doctors in civilian practice to give active support to the program by attendance at all the sessions.

The program committee is to be congratulated on its work of securing so many outstanding speakers at a time when demands on professional men are great. The presentation of such a diversity of important scientific subjects offers a form of postgraduate education that no member should overlook.

Only one change has been made in the preliminary program, with Captain Walter J. Pelton,

continued on page 27

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PROVIDENCE

ANNUAL DENTAL MEETING

continued from page 25

D.D.S., of the United States Public Health Service, chief dental consultant to state health departments, taking the place of Dr. Francis Arnold to present a paper on "Fluorides."

A NATIONAL PROBLEM

Of all the physical impairments to which the human frame is subject, dental defects are among the most common. This fact was brought forcibly to the attention of the American people when it was found that impaired and missing teeth were the leading reason for rejection among men examined for Selective Service early in the draft.

Although tooth decay occurs at every period of life, it develops most rapidly at the younger ages. New defects, it has been estimated, arise in the permanent teeth of children at the rate of about 1⅓ tooth surfaces per child each year. As a result of this rapid accumulation of dental impairments among children, it is not surprising that competent surveys show that more than 95 per cent of those reaching age 15 have already experienced some decay in their permanent teeth. In view of these facts it is unfortunate that most children do not receive adequate dental care. Dr. Henry Klein, of the U. S. Public Health Service, who has given intensive study to the problem of dental needs, estimates that in a representative group of school children the fillings necessitated by dental decay are being made at only about one sixth the rate at which the defects arise. The disparity between new fillings and new cavities is so great that any attempt to meet the dental needs of these children would require greatly expanded facilities and a much increased personnel. Under present conditions, a very large number of people in this country reach the adult age with dental defects which require extensive treatment.

Failure to repair injured teeth in time often leads to their loss, and the high incidence of missing teeth among the American people constitutes an important part of the dental health problem in this country.

There is clearly a great need in this country for the expansion of dental services as part of the public health program. To begin with, the new program should be centered around the dental needs of school children who are developing their permanent teeth, so that impairments can be remedied as soon as they arise. This alone would reduce measurably the loss of teeth at later ages. As dental facilities are developed and personnel increased, the program may be extended to the older ages. Meanwhile, research for the cause of dental cavities should be intensified. There is a likelihood that the American people are now on their way toward improving their dental health through better diet, through the enrichment of foods with necessary vitamins, and through the wider practice of mouth hygiene.

. . . Statistical Bulletin, Metropolitan Life Insurance Company, October 1943.

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INDUSTRIAL HEALTH

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INDUSTRIAL DENTISTRY: A NEW OUTLOOK

NORMAN H. FORTIER, D.M.D.

In a century of unparalleled scientific progress in every other field of endeavor, Dentistry has reason to be proud of its own advances in the field of technical and medical knowledge. Now in the present period of social, political, and economic transitions, shall we sit back in inflexible adherence to the tyranny of accepted customs, apprehensive, confused, or shall we step out and meet the challenge of our changing world?

Our problem is urgent! Industry is concerned—dental disease has been shown many times to be one of the most prolific causes of interference with industrial productivity, and this economic element has aroused the interest of industrial managers and labor leaders. The masses of people are concerned—there is increasing awareness on their part of the importance of dental health as an integral factor in general health conditions, and of the advantages of group health programs. Government is concerned—the political mind is wondering why this country, with the best-trained dental organization in the world, found 20% of its original draftees unfit for duty because of oral defects.

This concern on the part of industry, society, and government regarding the method whereby the dental needs of the people shall be met, confronts us with a problem for which we must prepare our own solution if we are to control our own destiny. Therefore, consideration of INDUSTRIAL DENTISTRY as an answer is imperative. That the American Dental Association is aware of its possibilities is evidenced by the formation of the American Association of Industrial Dentists at its meeting in Cincinnati last October.

What is INDUSTRIAL DENTISTRY? That dental service administered by a dentist or dentists in a clinic or dental hospital on a salary or fixed-fee basis to be paid for, either by the employer, or by voluntary or involuntary assessments on the employee, or by some insurance plan; or the service may be farmed out to one or more dentists. To be a really good service it should be a combination of two programs:

1. That which is part of the plant's health program consisting of examination and diagnosis of all oral conditions, treatment of oral conditions arising from the working environment, and of emergency conditions which adversely affect working efficiency.

2. Group programs for remedial dental service as the responsibility of the *employee*, with or without financial assistance from management, labor or other agencies, which will result in large-scale referral of workers for remedial dental care.

With such a plan, dentistry can exercise considerable control over the methods, the procedure, the standards, and the fees. Dentistry, serving a group of individuals banded together in a dental health plan, remains a private enterprise paid for by private enterprise. Such a plan would be very different from socialized dentistry which would be controlled by government through legislation, would be paid for by taxation, and might completely change our present form of dental practice.

In order to protect private practice, the A. D. A. has adopted a minimum standard for dental service in industry for guidance of industrial clinics. These need not be enumerated here; copies may be had on request. Briefly, this standard requires a staff of qualified dentists, in good standing in their local societies, with complete responsibility and with

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1944 National Convention

The American Association of Industrial Physicians and Surgeons has announced, through Dr. Edward C. Holmblad, its managing director, that the 1944 convention will be held at the Hotel Jefferson, St. Louis, Missouri, from May 8th through the 11th or 12th.

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INDUSTRIAL DENTISTRY

continued from page 29

adequate equipment, performing examinations and treatment of occupational conditions and emergencies, keeping proper records, educating and referring patients for remedial care. However, it is most important that the rules be strictly adhered to under supervision of the dental society, and that the project be self-sufficient and not an adjunct of a medical program, in order to assure a high standard of service and success of the industrial program.

A plan along the above lines is now in operation in one of the large war plants which, for the initial period is confined to the following:

1. Classification of employees' mouths acording to the extent of dental disabilities.

2. Education of employees concerning value of early and adequate dental service and maintenance of dental health.

3. Appointment service with dentists selected by employees at hours available to the employees.

4. Analysis of dental records to draft recommendations for future dental activities.

The set-up:

A dentist and an assistant have been employed. Cooperation of all dentists in the territory, is requested, so that the dental profession, the company, and employees will share in mutual benefit.

The dental appointment service *must* function so that referred employees will be able to get appointments, otherwise it will fail. Dentists are urged to see such employees on early or late shifts, early mornings, late evenings or Sundays.

All dentists who wish to cooperate in the plan are registered as cooperative dentists; they collect their fees from the employees in the usual manner.

Employees needing service are referred to their family dentists. If they have none, they choose one from an alphabetical-area list of all dentists. Cooperative dentists are designated by asterisks on the list. If certain dentists are available for special hours they are so designated. Otherwise, alphabetical rotation is the method of choice.

Our immediate need in Rhode Island is:

1. To appoint a Committee on Industrial Dentistry for the purpose of discussing the industrial dental problem with the Committee on Industrial Health of the Rhode Island Medical Society. (*At this printing, this Committee has been appointed.*)

2. To get the cooperation of medical directors of plants to interest the management in the development of dental services.

3. To make studies of the effect of dental health on absenteeism, production costs, and morale.

In this way we can take the steps forward so that we, the dentists, may lead the way for dentistry, instead of being carried along undesirable paths in the reconstruction program.

DECEMBER MEETING

The Rhode Island Industrial Physicians and Surgeons and the Rhode Island Industrial Nurses Club had their December meeting at the Ashton plant of the Owens-Corning Fiberglas in Ashton, Rhode Island on December 21, 1943. From about 9:00 P. M. on the members began arriving at the gate lodge to the plant. Each guest had to sign a slip and receive a badge of identification, and all were met at the personnel office by Mr. Rhodes, the safety engineer, and Dr. James Sheridan, the physician to the plant, and then conducted to the lecture room where a demonstration of the various products manufactured by Owens-Corning was given.

One interesting feature of the trip into the plant was the study of the personnel methods. A great many of the physicians tried out the machine used to classify the ability of prospective employees. The prospective employee sits before a switchboard with problems, questions and answers on it and, by the turn of certain dials, selects the answer which he thinks is proper for the problem at hand. The instructor on the other side can at once gauge his answers and rate him accordingly.

Mr. Haumasser, superintendent of the continuous forming department, with a group of guides then conducted the doctors and nurses on an extended tour of the plant. All saw the special formula glass beads poured into the hopper filters, coming down as two hundred and four fine strands, gradually spun onto a drum and made into a single thread. The entire process was followed through until the thread was twisted and wound on reels.

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COUNCIL RECOMMENDATIONS

At the November meeting of the Council of the Society the following resolutions were made after a detailed discussion of each:

Meetings

It was moved that the midwinter meeting of the Rhode Island Medical Society should be held on Monday, February 7, 1944, as a joint meeting with the Providence Medical Association.

It was moved that the dates for the Annual Meeting of the Society should be May 24 and 25, and it was moved that the meeting shall be held in Providence.

Charles F. Gormly Fund

It was moved that the President shall appoint a committee of three to make recommendations to the Council relative to the use of the balance of the Dr. Charles F. Gormly portrait fund.

Chiropractic Examination Board

It was moved that the President should write to the Governor of the State again citing the failure of the director of health to appoint two doctors of medicine to the board of examiners in chiropractic as required by law, and to ascertain, if possible, why the personnel of the board had been changed.

Delegate to the A. M. A.

It was moved that the Council recommend the name of Dr. Alex M. Burgess to the House of Delegates at its next meeting as the delegate from the Rhode Island Medical Society to the Annual Meeting of the House of Delegates of the American Medical Association. It was also moved that the name of Dr. William P. Buffum be submitted as alternate delegate.

Appointment of Committees

It was moved they recommend to the House of Delegates that the appointive committees shall be named at the time of the Annual Meeting to serve for the ensuing year, and it was further moved that the present appointive committees be continued in office until they or their successors are named in May, 1944.

Opinion on Wagner Act

It was moved that the original statement drafted by the representatives of the New England Medical Societies relative to the Wagner-Murray-Dingell Act be approved and that it be published and reported as the official statement of the Rhode Island Medical Society.

New England Council

It was moved that the president of the Rhode Island Medical Society be empowered to explore the possibility of a plan for a New England Medical Council for the purpose of bringing about a closer cooperation in the development of plans relative to organized medicine and in the furtherance of all phases of public health.

E. M. I. C. Program

It was moved that the report of the special committee appointed to study the Federal Emergency Maternity, and Infant Care Program should be accepted as an official statement of the Society.

BLUE CROSS MEMBERSHIP

With the re-opening of the membership list to Rhode Island doctors who are members of the State Medical Society, the Blue Cross is now prepared to accept enrollments from any doctor in active practice for himself and his family, as well as for any employees in his office.

By special araringement the wife of any doctor in military service may make application for herself and her children under 19 years of age.

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Council and Delegates Meet

Two very important meetings are listed for this month for the policy making bodies of the Society. On Wednesday, January 19, the Council will hold its regular bi-monthly meeting at the Hope Club in Providence, and on Thursday, January 27, the House of Delegates will assemble for its first meeting of the new year at the Medical Library.

HE ORDERS THE JUMP... BUT HE'S

FIRST TO LEAP



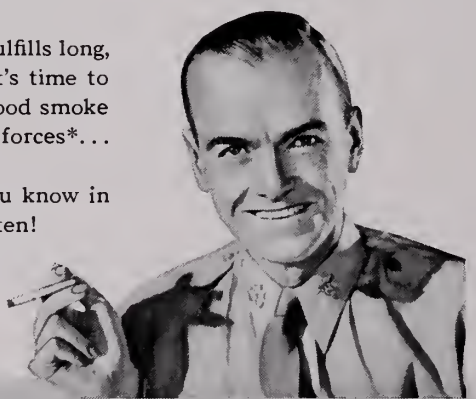
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MEDICINE IN THE JUNGLES

December 3, 1943

Dear Doctor . . . .

Eric Stone and I were talking tonight about the type of medicine that can be practiced even under jungle conditions, and it occurred to us that you (and others at the Rhode Island Hospital) might be particularly interested. As you know, the group was unfortunately separated some months ago, one, headed by Lt. Cols. Mahoney and Lawson to run a station hospital at a fixed post in the interior, and the rest of us scattered on a variety of missions. When 8 of us returned from one of these missions in September we found Eric had made plans for us to set up and run a field hospital ahead in the hill jungle. So about a month ago we (Bill Leet, Eric, Fred Webster, J. Dziob, myself and 2 non-Rhode Island Hospital officers—Capts. Garber and Grueninger) officially began to receive patients into a motley group of bamboo huts ("bashas") on what had recently been marsh in virgin jungle. Fortunately, the "dry"* season supervened, and our greatest initial problem, the engulfing mud was solved. Since then we have made great progress.

Our facilities were so limited at first that we had one ward with patients, but without a roof. We are still very much in the process of construction, carrying on our daily work, amid the debris and litter created by the coolies weaving the bamboo walls of our bashas-to-be, not to mention their indiscriminately deposited excreta.

We have been limited not only by lack of officer personnel (Eric and Bill are practically entirely taken up with necessary administrative work), but we have no nurses, and very few of our enlisted men had been trained in hospital work. But many of these ex-farm boys and pristine coal miners set in with a will to learn to read thermometers, give enemas, assist in operations, and all the tasks commonly assigned to nurses. Many of them have become quite proficient, even in this short time. As you can imagine, the long trek supplies have to travel did not ease that problem. Even bottles are scarce—elixir of terpene hydrate appears in a salvaged hair tonic bottle, and calamine lotion in a container recently holding that well named local product "Fighter Brandy."

Eric is commanding officer and also sees G-U cases in consultation, and has done cystoscopies; Bill Leet is Executive Officer and handles much of the administrative work, personnel problems, records, and a large part of the disproportionate amount of paper work accumulated even in a field hospital; Johnnie Dziob does the surgery and fracture work in collaboration with Freddie Webster who also handles admissions and frequently gives anesthesias; I am the entire present personnel of the medical service, and also in charge of the laboratory, pharmacy and sanitation; Capt. Garber runs the X-ray, and Capt. Grueninger is our E.E. N.T. man. Sam Clark is ahead running an aid station; he will be relieved by one of us in rotation. Milt Korb is back at the base and expected here soon to round out the complement.

Somewhat over one half the work has been medical (malaria, dysentery, dermatitis, venenata, respiratory infections, malnutrition (among the Chinese), and the "FUO's" which in spite of all the investigations I've been able to make are still mysteries.) There has, however, been considerable surgical work — mainly on the results of trauma, — and a fair amount of dispensary work which includes some Nagas as regular customers. (Parenthetically, the good-will created by American generosity, among this primitive hillfolk, bears tangible fruit, — within the past week, on two occasions I have treated stranded aviators carried in from the jungle by the Nagas, — incidentally one of them showed the transient glycosuria of "starvation diabetes.")

To get back to Eric's, and mine, original thought. We have tried to practice as scientific medicine as possible even up in this remote spot. We have set up a surgery (the only basha with a floor); we take all the x-rays our portable apparatus will do; my tiny lab. does the usual clinical routine work; Dziob

*I. E. relatively actual dryness never exists here.

continued on page 43

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DISTRICT SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

Annual Meeting

The election of Dr. Albert H. Jackvony as its new president, and the proposal by Dr. Emery M. Porter in his presidential address for a statewide Voluntary Health Council, consisting of lay and professional members, to initiate a definite program to further hospital, medical and health care for everyone in Rhode Island, highlighted the 97th Annual Meeting of the Providence Medical Association held on January 3.

Other officers elected were Dr. B. Earl Clarke, vice president; Dr. Frank W. Dimmitt, secretary; Dr. Herbert E. Harris, treasurer; Drs. Emery M. Porter and Kalei K. Gregory, to the executive committee for five-year terms; Dr. Harry C. Messinger, Trustee of R. I. Medical Library; and Drs. Alex M. Burgess, Emery M. Porter, Henry E. Utter, Antonio D'Angelo of Bristol, and George Davis of Cranston, as new delegates to the State Medical Society.

The scientific program of the meeting consisted of the presentation of a paper on "Carcinoma of the Endometrium" by Dr. George W. Waterman, and reports on the "Recent Poliomyelitis Epidemic" by Dr. Edward J. West of Chapin Hospital, and on the "Kenny Treatment of Poliomyelitis" by Dr. William A. Horan, chief of the division of crippled children of the State department of health.

Dr. Jackvony, vice president of the Association last year, was born in Providence where he received his elementary and high school training. He later graduated from the Rhode Island College of Pharmacy and he is now one of the three persons in the State who hold the degrees of Graduate Pharmacist, Pharmaceutical Chemist, and Doctor of Pharmacy. In 1915 he matriculated at Mount Vernon Institute, in Baltimore, where he pursued premedical studies prior to enrolling at the medical school at the University of Maryland, where he won the degree of Doctor of Medicine.

While at medical school he was appointed a member of a local draft board in this city, a post he later resigned to continue as a member of the student Army Training Corps at the University.

After a surgical internship at Franklin Square Hospital in Baltimore, where he also had charge of the clinical laboratory, Dr. Jackvony returned to Providence to enter general practice. In 1925 he began the practice of general surgery, a specialty he has continued ever since. He is visiting surgeon at St. Joseph's Hospital, consulting surgeon at the State Sanatorium, and associate surgeon at the Homeopathic Hospital. In addition he is a Fellow of the American College of Surgeons to which he was elected in 1932.

Dr. Jackvony is presently a member of the R. I. State Board of Appeals of Selective Service, and he has two sons serving with the armed forces. One son, Albert H., Jr., is stationed at Parris Island, North Carolina, with a marine unit, and the other, Edward A., is with a tank destroyer division now on maneuvers in Tennessee.

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ALBERT H. JACKVONY, M.D.

President of Providence Medical Association



C. T.

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- Obstructive Jaundice
- Hemorrhagic state associated with Primary Hepatic Disease
- Hemorrhagic conditions of Ulcerative Colitis, Sprue and Celiac Disease
- Hypoprothrombinemia of the Newborn

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DISTRICT SOCIETY MEETINGS

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Dr. B. Earl Clarke, elected vice president, is resident pathologist at Rhode Island Hospital. He is a native of Iowa, and he was graduated from the medical school at the University of Iowa in 1925. Following his internship he was assistant professor of pathology and bacteriology at Iowa, and then was an assistant in the department of pathology at Harvard University prior to coming to Providence.

DECEMBER MEETING

At the December meeting of the Providence Medical Association, held on December 6, the following action was taken:

The Executive Secretary was authorized to investigate the possibility of a plan whereby commercial exhibitors may display their products at the meetings of the Providence Medical Association, provided that not more than four exhibitors shall be allowed at any one meeting.

The Association authorized the Executive Secretary to contract for space for a display in the *Providence Journal*, at an appropriate time, of the names of the members of the Association who are in the service of the armed forces of the United States, such display to be paid for by the Association.

The incoming president in 1944 was authorized to appoint a committee of ten members to secure the enrollment of all non-members of the Providence Medical Association in the State Medical Society.

In accordance with the By-Laws a slate of officers for 1944 was proposed to be voted upon at the annual meeting.

The following doctors were elected to active membership: Drs. Marco Colagiovanni, Katharine K. Cutts, and Lewis T. Bennett.

The scientific program consisted of a talk by Dr. Oliver Cope, Assistant Professor of Surgery, Harvard Medical School on "Thymectomy for Myasthenia Gravis", and a talk by Dr. Chester M. Jones, Clinical Professor of Medicine at Harvard, on "Regional Ileitis and Ulcerative Colitis".

Dr. Oliver Cope discussed the theoretical mechanism of the weakness seen in striated muscles in cases of myasthenia gravis. Prostigmine and physostigmine apparently act by retarding the action of the cholinesterase. The disease resembles curare poisoning.

In 1901, a German pathologist found a tumor of the thymus at autopsy in a case of myasthenia gravis. Following that, isolated cases were subjected to extirpation of the thymus and to irradiation with rather variable results. Blaylock later in this country removed a tumor of the thymus with resultant disappearance of symptoms. Later cases operated by him were rather disappointing, however.

Dr. Cope reported eleven cases operated by him at the Massachusetts General Hospital. In one case which had a tumor, the tumor alone was excised with satisfactory results. In another case of tumor, the whole gland was removed. The other cases had no tumor but presented grossly abnormal appearance of the gland interpreted as hyperplasia. Dr. Cope stated that histological examination fails to reveal a definite hyperplasia in spite of the gross abnormality. Failure of three early cases was perhaps due to incomplete removal. The results obtained with improved technique have caused Dr. Cope and his colleagues to be very enthusiastic concerning this surgical therapy.

Dr. Chester M. Jones, Clinical Professor of Medicine at Harvard, presented a most instructive discussion of regional ileitis and ulcerative colitis in response to questions asked by Dr. Alex M. Burgess. The extent of lesions, differential diagnosis and treatment were covered. The lesions of ileitis may involve any part of the small intestine and are found in the caecum and the ascending and transverse colon. The treatment of ileitis is essentially surgical. Generous resection must be done. The care following such resection must be carefully continued to avoid deficiency states. Occasionally a patient goes for many years with considerable ileitis without requiring surgery. Operation is usually necessitated by fistula, obstruction or malnutrition.

Dr. Jones stressed the necessity of doctor and patient facing the fact that ulcerative colitis is a chronic incurable disease. Sigmoidoscopy must be done in every case of persistent diarrhea. Sulfonamides have been found of value in controlling secondary infections but do not cure the disease. In one case, penicillin controlled such infection in a miraculous manner when the sulfonamides had failed. Ileostomy is often a life-saving procedure and often prevents invalidism. Colectomy is sometimes indicated when ileostomy fails. Colored slides showing the mucosal lesions of ulcerative colitis were shown.

PAWTUCKET

The monthly meeting of the Pawtucket Medical Society was held in the Auditorium of the Nurses' Home, Thursday, December 16, 1943. After a short business meeting, Dr. Orland F. Smith, head of the Transfusion Service at the Memorial Hos-

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PHYSICIANS DIRECTORY

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MATERNAL MORTALITY

COMMITTEE ON MATERNAL MORTALITY

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CASE HISTORY

REFERRED to a member of the hospital staff by a non-member physician. Immediate admission to the hospital advised for observation. Age 23. Primipara. Patient had not been well since she had pneumonia in 1939. She developed multiple complaints and was taken by her husband to several doctors. Her symptoms were always considered of neurotic origin. Became pregnant in May, 1941. Pronounced nausea and vomiting. Marked asthenia. When first seen by the staff member about a week before her admission he considered her a typical picture of myasthenia gravis. Entered hospital January 30, 1942. Seen in consultation by neurological consultant who was unable to make a definite neurological diagnosis. Impression was that fatigue, exhaustion, food and vitamin deprivation played a part and that psychological factors were strongly operative also.

Delivered January 31 by low forceps after six hours labor of a six pound, six ounce, eight months baby.

Transferred to the psychopathic ward of the Charles V. Chapin Hospital February 7, 1942, eight days postpartum. Died on February 8, 1942. Diagnosis:—Bulbar Paralysis (cause unknown).

Discussion

This is another case which is difficult to classify. The history is incomplete. Considering the fact that there is a story of ill health presumably of nervous origin going back for several years before she became pregnant and that her pregnancy was apparently normal except for nausea and vomiting, the committee considered her death non-obstetrical.

The question of vitamin deficiency in the vomiting of pregnancy deserves more than passing notice. In this case it may have been the determining factor. So called pernicious vomiting of pregnancy terminating in death is apparently much rarer than it was some years ago. Formerly a mild case was put to bed on a so-called "bland diet" usually essentialy a carbohydrate diet without vitamins. If the vomiting continued fluids were restricted.

A vicious cycle was established—the worse the vomiting the more the body tissues were dehydrated and the greater the dehydration the worse the vomiting. If this continued long enough vitamin deficiency resulted with the development of profound asthenia and in extreme cases, a polyneuritis similar if not identical with Karsakoff's syndrome and delirium tremens. If the patient happened to be neurotic and spineless it was quite possible to transform a mild and relatively innocuous condition into a serious or even fatal one. That may have been what happened in this case.

These cases are, of course, not primarily gastric though they were treated as such.

In obstetrics as in all other branches of medicine one must always bear in mind that the patient must be treated first and then the disease. Even though a disease may require a restricted diet, the body still requires a certain minimum of protein, carbohydrates, fats, vitamins and minerals. It may well be that in this case the minimum was not supplied. This is not the place to discuss in detail the treatment of the vomiting of pregnancy; suffice it is to say that the first measures should always be psychological and if that is ineffective measures to supply fluids to the tissues (glucose solutions by vein) and vitamins.

CASE HISTORY

Age 31. Gravida 2. Para 2. One previous uncomplicated pregnancy. A year and a half previous was told by her physician that she had a slightly elevated blood pressure. Due date October 17, 1941. First visit to a physician in seventh month when there was extensive edema. Blood pressure not known. Rising blood pressure last two months. Blurred vision for two weeks.

Admitted to a hospital September 30, 1941, in active labor. Blood pressure 234/150. Urine showed albumen three plus and occasional casts. Delivered a living baby in good condition weighing 5 lb. 10 oz. after twenty hours and thirty minutes of labor. Blood pressure continued elevated; 200/110 on discharge. Albuminuric retinitis. Febrile

Continued on page 44



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DISTRICT SOCIETY MEETINGS

continued from page 39

pital, gave a brief but interesting talk on the importance of the Rh factor in relation to patients needing multiple transfusions and in pregnant cases needing transfusion.

Mr. Robert Hannaway of the Petrogalar Company presented a movie depicting the etiology and treatment of postpartum hemorrhage.

MARY-ELAINE J. ROHR, M.D.

MEDICINE IN THE JUNGLES

continued from page 35

and Webster have ingeniously constructed fracture contrivances out of all sorts of material, and have made numerous improvisations in the operating room; and I have autopsied our only death to date.

We are having a grand time at it all, and our collective health has been excellent. It would not be in the Rhode Island Hospital tradition if we did not periodically exhibit our wares, and we have regular "grand rounds." I enclose a copy of the program the medical service is showing tomorrow, and I believe Johnnie and Freddie have selected some interesting surgical and fracture cases for presentation.

1. Falciparum Malaria with 4 weeks of "neurasthenic" prodromal symptoms. (Foster — Wd 5)
2. Vivax Malaria occurring in a patient in hospital for 18 days for treatment of dysentery. Possibility of hospital infection, or dysenteric type of malaria. (Davis—Wd. 5)
3. Malarial Relapses. Precipitating factors vs. rhythmic recurrence. (8 cases — Wds 5, 6, 7)
4. Dermatitis Venenata. Possible causes. (6 cases—Wds. 5, 6, 7)
5. Mild asymptomatic jaundice in a patient with subsiding upper respiratory infection. (Metzger — Wd 7)
6. Presentation of Interesting Films (Capt. Garber)
   - A. Complete situs inversus of thoracic and abdominal viscera. (Chinese)
   - B. Non-pathological anomalies of the diaphragm. (2 cases)
   - C. Renal Calculus (?) discovered on routine film for back trauma. (Black — Wd 5)
7. Follow-up on Treated Amebic Dysentery. (Dorsey — Discharged)

I hope it won't be too long before we are doing our bragging at the Saturday A.M. conferences at Peters House.

(CAPTAIN) IRVING BECK, MC

48th Hospital Unit

FROM THE SECRETARY'S DESK

continued from page 33

All applications must be made through the executive office of the R. I. Medical Society, and requests for applications or for information should be directed to Mr. John E. Farrell. Applications will close on February 15, and benefits for those enrolled at this period will become effective on March 1, 1944.

INVITATION TO DENTAL MEETING

The Rhode Island State Dental Society, which holds its annual meeting this month, has graciously extended an open invitation to all members of the State Medical Society to attend the meeting at the Narragansett Hotel on Tuesday, January 25th, at 8:15 P. M., at which time Henry Sage Dunning, M.D., D.D.S., F.A.C.S., professor of oral surgery at Columbia, will present the subject "Surgery of the Mouth, Face and Jaws, of Interest to the General Practitioner".

BOARD OF OPHTHALMOLOGY

Effective the first of the year the executive office of the American Board of Ophthalmology was transferred to Portland, Maine. Communications to

Continued on next page

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MATERNAL MORTALITY

Continued from page 41

temperature fifth to eighth day with clumped pus cells in urine. Blood N.P.N. and creatinine gradually rose, reaching 74 and 4.0 respectively. Blood pressure on discharge 200/100. Discharged November 1, 1941. Died on January 15 at home, of uraemia.

Diagnosis. Toxaemia of pregnancy (nephritic type); acute pyelitis; chronic pyelonephritis.

Discussion

This case was classified, perhaps erroneously, as a non-obstetrical death. The decision was based on the following facts:—her blood pressure was elevated before she became pregnant; her blood pressure remained elevated after delivery (in toxaemia blood pressure usually falls fairly promptly); her death did not occur until two and a half months after delivery; her blood N.P.N. and creatinine were elevated (not the usual findings in uncomplicated toxaemia).

There can be little doubt that pregnancy shortened this patient's life. Her prenatal care was inadequate. She did not consult a doctor until her seventh month and marked edema had developed. Apparently little attention was paid to her previously existing high blood pressure. It gradually rose for two months. No adequate treatment was instituted until it reached 234/150 and she was admitted to a hospital. Her eye grounds were not examined. During those two months the added burden of pregnancy was causing further damage to already damaged kidneys. Rest in bed with appropriate treatment and, if that failed, induction of labor, would probably have limited that damage and prolonged her life. Here is another case illustrating the danger inherent in hypertension in pregnancy.

FROM THE SECRETARY'S DESK

Continued from page 43

the Board should be addressed to this city, in care of P. O. Box 1940. The Board has announced that the 1944 examinations will be held in New York City on June 3 and 4, and in Chicago on October 5, 6, and 7.

WASHINGTON INFORMATION BUREAU

In mid-December representatives of the Arizona, California, Colorado, Idaho, Oregon and Utah medical associations, in meeting at Salt Lake City, unanimously approved a resolution whereby the eleven western state medical societies shall establish and maintain a service bureau in Washington, D. C., for the purpose of informing governmental agencies and representatives with regard to public health matters affecting the western states and to inform the medical profession of all federal government activities affecting the profession.

ELECTED TO FELLOWSHIP

Notification has been received from the American College of Surgeons that the following initiates from Rhode Island were accepted into Fellowship in the College in 1943: Dr. Henry A. Campbell of Pawtucket, Dr. Hartford P. Gongaware of Westerly, president of the Washington County Medical Society, and Dr. Francis J. King of Woonsocket.

BUY WAR BONDS

Should VITAMIN D *Be Given Only To Infants?*

Vitamin D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startling high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Parks* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Parks: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:11, July 1943.

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**Facts from: Proc. Soc. Exp. Biol. & Med., 1934, 32, 241-245; N. Y. State Jrnl. of Med. Vol. 35, No. 11,590; Arch. of Otolaryngology, Mar. 1936, Vol. 23, No. 3,306*

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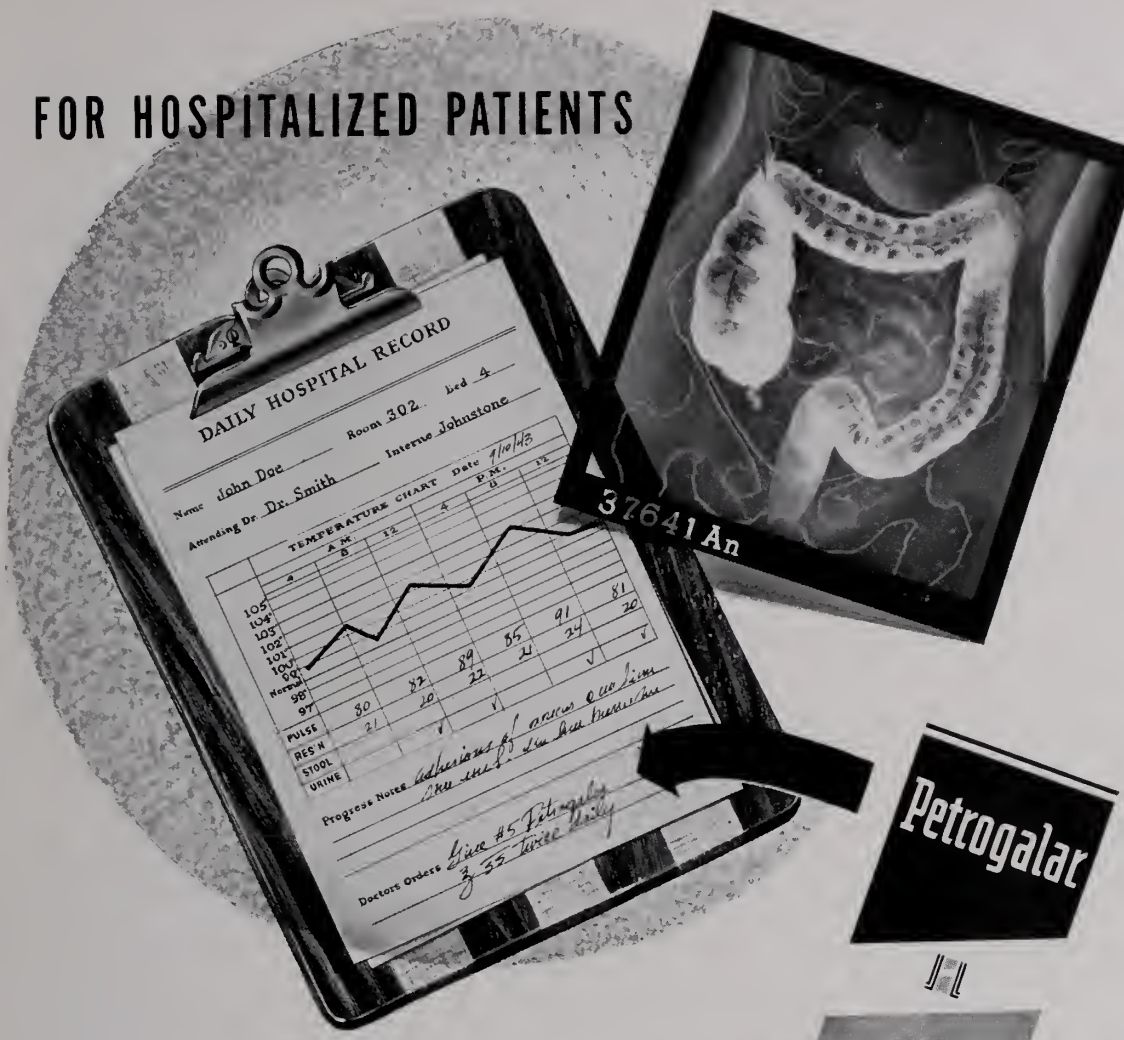
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Volume XXVII, No. 2

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THE RHODE ISLAND MEDICAL SOCIETY
THE RHODE ISLAND DENTAL SOCIETY



"A MAN OF FEW WORDS AND FEWER MINUTES—THAT'S MY DOCTOR!"



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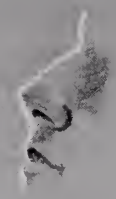
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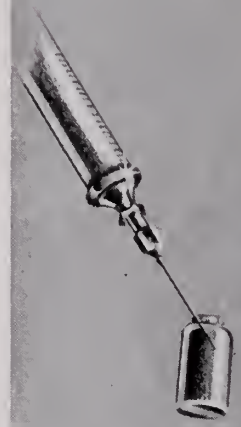
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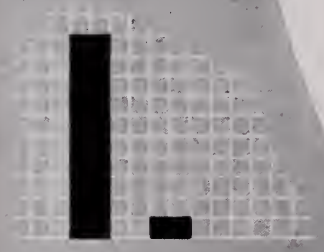
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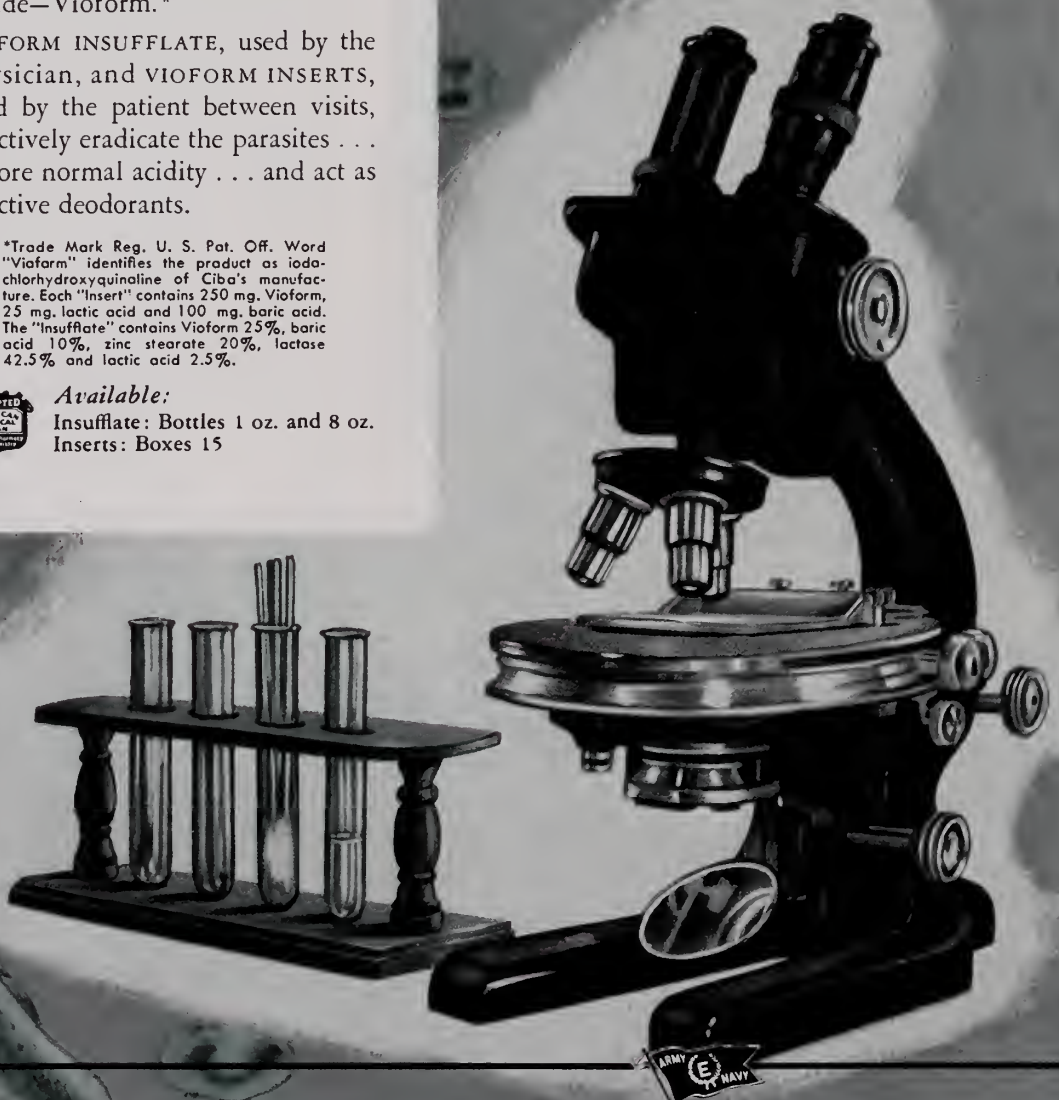
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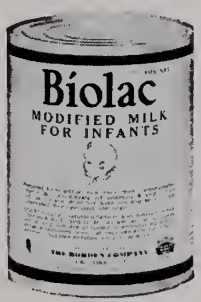
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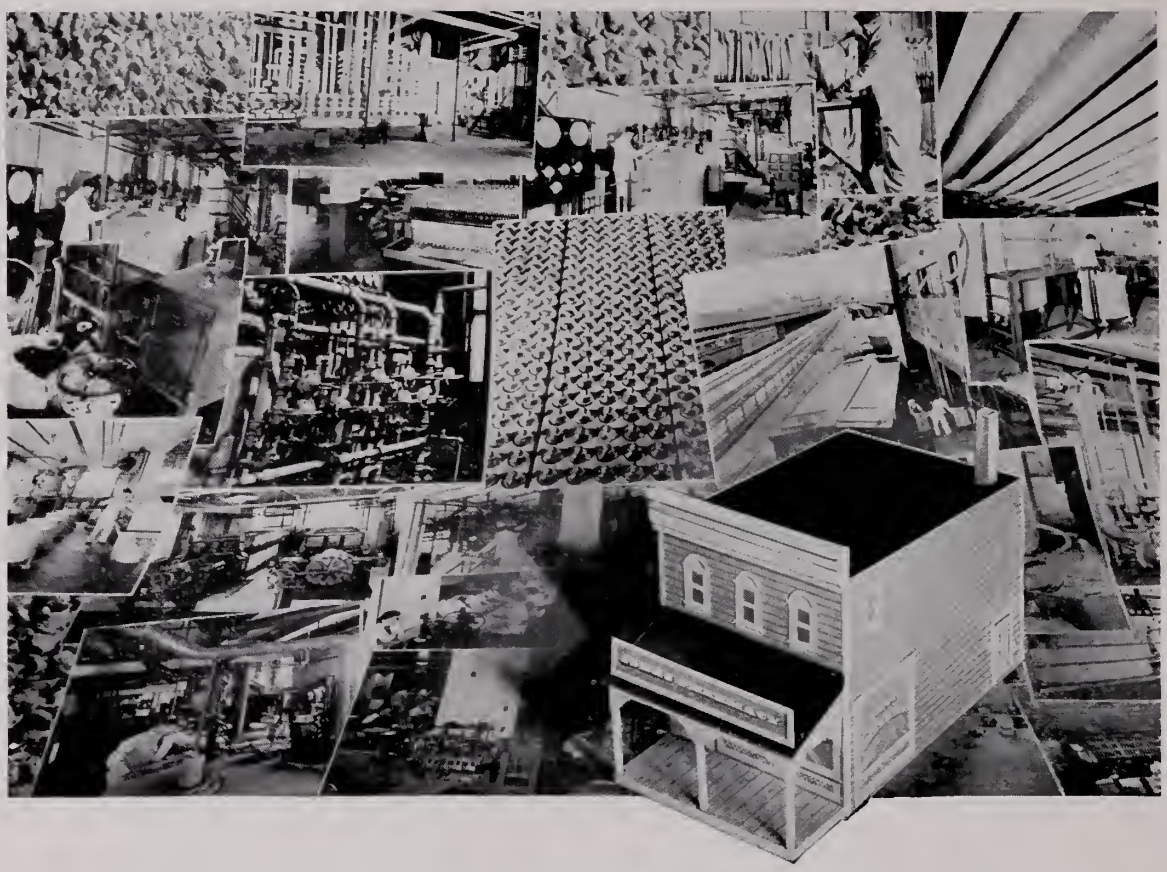
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R. I. Dental Meeting					
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The RHODE ISLAND MEDICAL JOURNAL

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MEDICAL PROBLEMS OF THE TROPICS

(Reports of Medical and Surgical Work by Rhode Island Doctors Stationed in India)

(Army life for the medical man has usually, we believe, been highly unsatisfactory. Occasional periods of frenzied work have punctuated long stretches of forced inactivity. Then it has been easy to vegetate.

Numerous reports from the Rhode Island Hospital Unit show us that this is not true of them. Our January number had an interesting paper by Drs. Cutts and Lawson and a letter from Dr. Beck giving a glimpse of the scientific interest shown by the sub group he was with.

Dr. Dillon has sent us an account of the bimonthly meetings conducted by the main group and we give below some of the reports. Kala-azar and tropical fever may seem foreign to us here but there are forebodings that such bizarre matters will become exceedingly pertinent to us when the boys come marching home.—THE EDITOR)

Kala-Azar Infection

The first of these meetings was held on June 23, 1943. Lt. John A. Dillon of the Medical Service presented a case of Kala-Azar with demonstration of Leishman-Donavan bodies from splenic punctures. It was noted that in spite of six months of intermittent fever and thirty pounds weight loss the patient was cheerful and in good spirits, a characteristic of this disease. Physical examination was remarkable for emaciation (weight 90 pounds), anemia, cervical and axillary lymphadenopathy, splenomegaly (to the level of the umbilicus) and signs of tuberculosis of the right upper lobe. Chest film confirmed the pulmonary findings and showed enlarged hilar glands though sixteen sputa examinations for Koch bacilli were later negative. It was suggested that the pulmonic disease could be consistent with Kala-Azar infection of the lungs.

Prompt and steady recovery took place on treatment with intravenous urea—stibamine, and after one gram of the drug, smears from splenic puncture showed decrease in number of Leishman-Donavan bodies which then were intracellular. The drug was discontinued because of development of peripheral neuritis. On discharge on the nintieth day chest film was normal, spleen was not palpable and patient had completely recovered. Laboratory data was remarkable for leucopenia, secondary anemia and a positive Formol gel test. The case was discussed by members of the medical and surgical services and visiting medical officers.

Acute Abdominal Surgery

On July 8, 1943, Lt. Col. W. A. Mahoney reviewed some of the recent experiences of the Surgical Service in acute abdominal surgery. It was noted that the common abdominal emergencies met were acute appendicitis, ruptured spleens, perforated bowel from external trauma or intestinal ulceration, as from typhoid, and ruptured liver abscess. The ruptured spleens were most often caused by the kick of a horse. These patients had splenomegaly in a majority of instances and it was felt that the spleen was thereby more vulnerable to trauma. Immediate operation in these cases is imperative as soon as the diagnosis is firmly suspected to minimize shock which sets in rapidly and is profound. The spleens removed were large and the tears star-shaped and located about the hilus. Anto-transfusions were indicated and used in all cases along with saline and plasma. One patient received 2200 c. c. of his own blood and 600 c. c. of plasma at the time of operation. Anesthesia was spinal supplemented by ether inhalation as necessary. Mortality was low.

Tropical Ulcer

Also at this meeting Major J. M. Beardsley discussed the treatment of Tropical Ulcer. He noted that this condition has always been one of the most resistant surgical diseases that occurs in the tropics.

Several patients were shown with ulcers in various stages—untreated, during the period of treatment and following recovery. Because of the general unsatisfactory results that have been attained

continued on next page

in attempting to treat this disease from an etiological stand point it was recommended that treatment follow basic surgical principles. This consisted in early excision of the sloughing ulcer, wet dressings and either pinch or split skin grafting after a period of about 10 days. Satisfactory results followed this approach to treatment with a definite shortening of hospitalization.

Subsequent to this talk the end results of 21 treated cases, in which the above methods were applied was published in the C. B. I. Field Medical Bulletin. The average hospital stay for this group was from 25 to 30 days.

Malaria

On July 21, 1943 at the regular fortnightly meeting malaria was the topic of discussion. Patients recovering from various types of malarial infections were shown and the many problems of therapy discussed. Lieut. Dillon presented case reports of vivax and falciparum infections. Pre-coma and cerebral malaria cases were considered as to diagnosis and treatment.

Blood, spleen and bone marrow smears illustrating many forms of malaria parasites were shown by Lt. Wm. J. H. Fischer, Jr.

At the fortnightly staff meeting of November 10, 1943, Lt. Col. Herman A. Lawson and Captain John A. Dillon presented further reports of experience with malaria.

The well-established and previously observed difference in racial susceptibility and immunity was clearly shown in our experience.

The greater virulence of malignant tertian in contrast to benign tertian malaria was evident in the greater duration of fever in the former, but was more strikingly shown by the general clinical state of the patient, by the degree of prostration accompanying and debility following the acute illness, by the signs of cerebral involvement such as stupor coma or mania, by anemia, jaundice, etc. Moreover it was necessary to use quinine in 15% cases of falciparum infection in one racial group, either to supplement atebrin treatment or as initial treatment, whereas quinine was not used in any cases of vivax infection. Finally, deaths occurred only in falciparum infections.

Preliminary observations on the effect of larger doses of atabrine were reported. In one group, patients were given double the usual dose of 0.1 gm t. i. d.; in another group the double dose was given during the first 48 hours only, then followed by the usual dose 0.1 gm. t. i. d. This was done because it has been suggested that optimum results in the use of atabrine would be obtained, as with sulfanamides, by the use of large initial doses to obtain an effective blood concentration early. Results in this study have failed so far to show any advantage in employing larger doses.

It was also noted that, contrary to our expectations, the duration of illness prior to treatment made little difference in the subsequent course of this disease.

Amebic Abscess of Liver

On September 1, 1943 Major Jesse M. Gibson addressed the regular meeting and discussed amebic abscess of the liver. He presented a case of amebic abscess of left lobe of the liver which ruptured into the peritoneum and gave signs of acute, perforated ulcer, but with no preceding symptoms. The patient was operated three hours after rupture, the abscess was drained and emetine was started at once. Plasma, saline and glucose were used intravenously. The patient made a remarkable recovery, the wound healing in 22 days.

It was noted that amebic abscess occurs more frequently in men than in women by 20 to 1, usually between the ages of thirty to fifty. The typical case comes on after 12 to 18 months residence in the tropics following an attack of amebic dysentery. Fever may not appear for four to six weeks after dysentery and the onset is insidious and the diagnosis difficult. Amebic abscess has a predilection for the right lobe of the liver and symptoms may arise from irritation of the diaphragm or penetration into the lungs. Tenderness in the inter-costal spaces overlying the abscess is frequent. At the conclusion of the presentation a general discussion was held.

Relapsing Fever

On September 15, 1943, Lieut. D. Richard Baronian discussed thirteen cases of relapsing fever studied by him. He stated that patients complained chiefly of sudden onset of feverishness, with or without chills, intense headache and generalized aches, particularly in the calves of the leg. The temperature which was remittent in character was usually 103° - 105°, and tended to last from 6 - 9 days in the untreated cases ending usually in a crisis of profuse sweating, the temperature falling to subnormal or normal. The resulting afebrile period lasted from 7 to 9 days and sometimes longer, and was followed by a relapse usually milder and of shorter duration than the first attack. As a rule, in the untreated cases there were one or two relapses followed by cure.

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THE PRACTICE OF ORAL SURGERY BY THE GENERAL PRACTITIONER*

HENRY SAGE DUNNING, M.D., D.D.S.

The Author. *Henry Sage Dunning, M.D., D.D.S., F.A.C.S.; Professor of Oral Surgery, Columbia Univeristy, New York*

I HAVE been greatly interested in dental surgery and surgery of the face and jaws for a long time, and have given similar talks on this subject at many dental meetings, as I think that the topic is a most important one for every practicing dental surgeon at this time. I do not like the name Dentist for I believe that we are all practicing surgery and I think that you all are DENTAL SURGEONS and that you must practice along surgical lines.

The dental surgeon is performing more surgery than ever before. There are several reasons for this:

1—There happens to be a global war raging and even if you are not in the service of your country you probably will get some cases where minor surgery will be indicated sooner or later.

2—Economic conditions make it important for the medical and dental practitioner to refer as few patients as possible to the specialist.

3—The use of local anesthetics make it possible for the dental surgeon to do quite an extensive operation if he does not cause pain.

4—The dental surgeon in the smaller towns located near or on the main highways is called upon to help the general surgeon in the care of many automobile injuries.

5—The student is better trained upon graduating, and he has the opportunity of working in many dental clinics where he obtains much valuable experience.

My concern today is that we should train the dental surgeon to be a surgeon. At present oral surgery is only taught in the dental schools and in many cases the course is not adequate. In most dental schools the teaching of operative and prosthetic dentistry is stressed and oral surgery is considered relatively unimportant. The dental surgeon upon graduating sends much of his work out of the office, that is, the construction of his inlays, bridges, dentures, etc., to be made by experts, but he tries to perform all the surgery that he thinks he can take care of and he often gets into trouble because he over-estimates his ability to perform certain operations. The dental graduate should be urged to take an internship upon his graduation and if he is going into surgery he ought to become connected with some hospital clinic where he can continue treating not only surgical patients but also can continue the study of disease.

One of my chief criticisms of the dental graduate today is that he does not realize when he is dealing with a sick person. He may plan an elaborate dental reconstruction program or a severe operation without realizing that the patient is not in fit physical condition to withstand such procedures. I am anxious to send the dental graduate to his practice with a feeling that he is a surgeon and not a mechanic, that he is a member of the great family of physicians and surgeons, and to teach him how to "size up" his patient, and to make a careful examination which will be well recorded on a sensible chart, to enable him to make a correct surgical diagnosis, and to give the patient a painless and aseptic operation either in the office or in the hospital. This service should be comparable to the service rendered by a first class oto-laryngologist or any of the other surgical specialists.

The dental surgeon should feel that the patient is his first and only real concern. He cannot for one moment think that the laws that govern his professional activities are different from his surgical confreres. If he causes a break in the continuity of the skin or mucous membrane which produces a flow of blood, he is a surgeon. Some one has said that it is difficult to distinguish between minor and major surgery, that minor surgery may become major surgery in a few hours. I have seen this take place many times and I have felt happy in knowing that in most cases patients, when they have become dangerously ill, have been surrounded

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*Presented at the 66th Annual Meeting of the Rhode Island State Dental Society, at Providence, January 25, 1944.

by all the benefits that a great hospital could give them. We must give the patient our best efforts and all the skill, knowledge, sympathy and kindness that we possess. In order to do this we must keep ourselves in good physical condition and have some intelligent plan of action in treating our patients. We know that people come to us because they have some kind of trouble, real or imaginary. To them it makes very little difference. It is our job to find the real trouble. I am sorry to say that too many dental surgeons are apt to take things for granted and many will operate upon the receipt of a slip from another dentist telling him what to do. The idea of operating upon a patient because someone else has marked up a chart is a very poor plan. No surgery should be performed unless the operator feels that there is a definite reason for such an operation. This is not practicing surgery as surgery should be practiced, and this sort of thing does not in any way "enhance" the practice of dental surgery.

Surgical Objectives

The object of every type of surgeon is three-fold:

1—To relieve suffering; to make the patient comfortable if possible.

2—To remove pathology or disease, generally the cause of the trouble.

3—To repair injury that might have been caused either by disease, injury or surgery.

The above should be uppermost in our minds, and in order to carry out this line of action we must make a careful diagnosis in order to know what we are going to do. A careful examination is made of every patient after the history has been taken, even when a tooth is to be removed. We must be satisfied from our findings that such and such is such and such without taking anybody else's word for it, for the operator alone will be held responsible for the outcome of any type of treatment rendered. The dental profession at present is very keen about diagnosis. There have been many courses given in oral diagnosis and it is carefully taught in all of the dental schools. A diagnosis is made by correlation of the principal points in the history with the clinical findings and is helped by special agents such as radiographs, biopsies, cultures, etc.

All physical disturbances or troubles can be classed under the four old headings:

1—Mal-formations, congenital and acquired.

2—Inflammation or disease.

3—Trauma or injury.

4—Neoplasms or neogrowths.

We should never try to make a snap shot diagnosis except for "fun". It may get us into trouble. Every diagnosis should be made by elimination. We must, to the best of our ability, prove to our own satisfaction that our diagnosis is correct before attempting to treat the patient. At this time, I would say that if the patient is not entirely satisfied with our findings, it is always a good idea to suggest a consultation. I think the bigger the surgeon is, the more he will welcome the opinion of one of his colleagues.

Cooperation with the Doctor of Medicine

We have stated that the treatment of the patient depends on the diagnosis. All treatment is divided into:

1—Medical, dental medicine.

2—Surgical, dental surgery.

Many of our cases need the attention of a good medical man in conjunction with our services, and we should cooperate with the physician as closely as possible. It is impossible for the dental surgeon to keep up with the strides that have been made in modern medicine. And I believe that we should be very prompt in referring patients with medical symptoms to the proper physician for treatment when they come to our attention. Having taken care of the medical side of the picture, we now come to the surgical treatment of our patient. We must decide:

1—What type of an operation the patient requires.

2—Where it should be performed, and

3—What kind of an anesthesia is the best for this special case.

The operator is the judge as he knows better than anyone his ability to do such and such under certain conditions. All operative patients are divided into office and hospital cases, and the dental surgeon must know when to send his patient to the hospital for surgical care.

If more dental surgery was performed in the hospital, the doctor and the patient might be better friends in the end. Too many operations are attempted in the dental office that have to be completed in the hospital at a later date. It is imperative that the surgeon should be on the staff of some good hospital in his community if he is to practice surgery, as I have pointed out earlier in this paper.

Wherever the operation is to be performed, we must have a definite plan of procedure, good assistants, the right anesthetic and proper instruments, and sterile supplies. Many operations have failed

for the lack of one or more of the above. Many failures have occurred on account of the inadequate preparation on the part of the surgeon, due to his inability to judge the problem in hand. If the operation is to be done under local anethesia, the operator should be kind and firm, and have plenty of confidence in himself. His confidence and his cheerful demeanor should be so infectious as to, as near as possible, make the patient feel that both he and the doctor were going to have a pleasant adventure. I often tell our students to keep talking to the patient about anything that has nothing to do with the operation. Keep them interested and do not operate in a glum, silent manner that suggests that you are not vitally interested in their every comfort. Most patients who are to have a fairly extensive operation performed can be helped mentally by the administration of some kind of a sedative given about an hour before the operation whether the anesthetic to be used is general or a local agent.

Operation Procedures

Regarding the anesthesia to be used. You are the operator and you alone are responsible for the outcome of the operation. I do not think that we ought to try to please the family dentist or the family physician if by so doing we embarrass the treatment of the patient. I do not see any reason for placing a person under deep surgical anesthesia unless it is definitely indicated. If general anesthesia is desirable, a good anesthetist should administer the drug and the patient should be surrounded by all the precautionary measures possible, whether in the office or in the hospital. I am sure that nitrous oxide and oxygen anesthesia is the most difficult anesthesia to give when the mouth is open as it must be for an oral operation. I say this with great conviction even though this gas was first used by a dentist, Horace Wells, and has been used by the dental profession for a great many years.

The operator alone can decide what type of anesthesia should be given after a careful examination of the patient who is to be operated upon.

As to the operation. It must be performed with the best surgical technic possible, painlessly and with as complete asepsis as can be maintained. There should be a minimum amount of shock to the patient, and little trauma to the parts and all wounds should be left in the best possible condition for early healing. We must know when to suture and when to drain. We should guard against accidents, lacerations of the soft parts, fracture of the roots, alveolar process, the tuberosity, dislocation of the mandible, openings into the antrum, roots in the antrum, sharp edges of bone, injury, to adjacent teeth, breaking of instruments, needles, and so forth. We should have all pathological tissue examined carefully under the microscope and keep a record of the findings. There is always a chance of things going wrong in any operation and I think that the surgeon should tell the patient in a quiet sort of way when the operation is not successful, repair the injury and finish the operation as soon as possible.

I am positive that any one performing much surgery will sooner or later run into trouble. There is always a certain amount of "grief" attached to our calling even though we do everything that we possibly can to guard against untoward incidents. One of the main objects of this paper is to try to point out some of the "pitfalls" in the practice of dental surgery, so that the younger men entering this field will not only find it more attractive, but will also avoid some of the unpleasantness that we older men have encountered in the past.

Importance of Post-operative Care

In conclusion, I would say that the post-operative care of the patient is in many cases almost as important as the operation, and that many dental surgeons do not seem to appreciate this phase of our work. Every post-operative case should be carefully "deposited" in a quiet room and made to rest whether they have been given a local or a general anesthetic. They should not be allowed to leave the office unless discharged by the operator with full post-operative instructions as to what to do. It is difficult to tell how the administration of drugs, an anesthetic, and an operation will effect a person. The reaction of each person is different and we must endeavor to guard each patient individually.

The surgeon should have a definite follow-up system so that he will surely see the patient not longer than two days after an operation of any importance. If they do not return, they should be communicated with and the surgeon should call upon them if they cannot come to him. The patient should be able to get in touch with the doctor day or night and weekends, as he is responsible for their condition. This is most important in cases of infection as these cases should be seen every day by the surgeon or his assistants. If this cannot be arranged I feel that the surgeon should not become involved in the case and that the patient

continued on next page

should be referred to someone else. I have tried to point out to you some of the phases of our work that seem to me to be important. It is all very old advice, and I would not have bored you all with it if it were not for the fact that I constantly see cases that are difficult due chiefly to a lack of training on the part of the dental surgeon who has had charge of the patient. I have dealt mostly in this paper with generalities, but I hope to go into some of the details of our work with lantern slides to follow.

In closing I express the opinion that experience is the best teacher and that any man who practices surgery should give a certain part of his time to clinical and hospital work. No practitioner is too busy to do this, if he has time to practice surgery at all.

MEDICAL PROBLEMS OF THE TROPICS

continued from page 58

The patients tended to be acutely ill. Splenomegaly was present in one half of the cases only and lenkocytsis was absent in the majority of cases, a low normal WBC being the rule, contrary to the usual statements. Diagnosis was readily made by finding the spirochete in blood films stained by Wright's stain.

All of the cases, both treated and untreated, recovered. However, the untreated cases tended to have one or more relapses and a resulting longer convalescence, while the treated cases seldom had recurrences or had very mild ones.

The majority of cases were treated with neoarsphenemine intravenously in dose ranging for .2 gm to 45 gms. with good results. However, because two cases had all the signs and symptoms of shock on the day following neoarsphemamine therapy, it was felt that .45 gm. was too large a dose and that smaller doses would suffice, or that the drug should be given in small divided doses. It was also pointed out that the drug should be given early and not when the crisis was imminent, because a very grave reaction might occur due to great destruction of the spirochetes and liberation of toxins with corresponding aggravation of symptoms and fatal collapse. Patients were shown, and the subject discussed by members of the staff and visiting medical officers.

Catarrhal Jaundice

On October 13, 1943 Captain Robert G. Murphy presented observations on recent cases of Catarrhal Jaundice presumably due to a filtrable virus.

In these cases previous upper respiratory infection or gastro-intestinal disease played no part. The cases showed great variability in mode of onset, intensity of the jaundice duration and degree of fever, and the severity of the illness which ranged from a mild insidious course to severe prostration with chills, high fever, and severe headache and backache.

Many showed chills, headache, and orbital pain. The majority showed bile in the urine, change in color of the stools, right upper quadrant tenderness, and almost complete loss of appetite. In all there was either leucopenia or a normal white blood cell count.

In the majority there was evidence of extensive liver cell degeneration as shown by greatly increased urobilinogen in the urine.

In discussing the differential diagnosis it was noted that the onset of the illness in these cases before jaundice was apparent was often identical with that of malaria and dengue fever.

It was further observed that some cases of Weils disease, yellow fever, acute yellow atrophy and catarrhal jaundice may have almost identical symptomatology so that they must all be considered until such time as the laboratory evidence or subsequent courses establish the diagnosis.

Treatment of Burns

Treatment of burns was discussed by Lt. Thomas Perry on October 27, 1943. He noted that the incidence of burns in this army camp is low when compared with similar camps. This is largely due to lack of gasoline burning equipment. However, there have been sufficient cases to form some opinion of the pressure dressing treatment. Morphine analgesia and a minimum of debridement, except in very dirty cases, is recommended. Half to one or more grains of morphia may be used. Ointment pressure dressings are then applied. In the absence of large amounts of gauze and elastic bandage we have used jute fibre to add bulk to dressings and muslin bandage for pressure. During the initial treatment of the burn and for the first few days thereafter large amounts of plasma should be given using the hematocrit and percent of body burned as guide to dosage. Sulfadiazine in prophylactic doses is used for 5 - 7 days. Dressings are not changed for 10 - 14 days provided there is no systemic evidence of infection.

POST-WAR PLANNING AND SOCIAL ACTION*

HERMAN FINER, PH.D.

The Author. *Herman Finer, Ph.D., Special Consultant on Post-War Reconstruction to the International Labor Organization; formerly a lecturer and reader in Public Administration at the University of London; Member of British Civil Service Arbitration Tribunal; Member of Council of British Institute of Public Administration .*

(In publishing this summary of the lecture given under the sponsorship of the Providence Council of Social Agencies the editorial Board of the R. I. Medical Journal does not express thereby any approval whatever of the conclusions advanced by Dr. Finer. The abstract is presented here that the medical and dental profession of this State may be informed about the far-reaching program advocated by a consultant to the International Labor Organization. . . . The Editors.)

TREMENDOUS changes, changes without precedent in the history of the world, are occurring in the social functions and ideas of every state in the world. These changes are both extensive in the number of people they affect, and intensive and profound in the hopes and the feeling they arouse. The prodigious miracles of production in this war have given the common man an ineradicable conviction that society can do whatever it wishes to do in the reshaping of the conditions in which we live. The tribulation of millions, not yet at an end, has caused more people to ask more searching questions than ever before whether our social habits and economic methods hitherto are fitting for a democratic civilization. By the end of this year five million American soldiers will be overseas, and neither they nor their families will in the future let anything stand in the way of jobs for all—and that is one thing which must be recognized by statesmen; that men and women want jobs because they seek a modest welfare, security and self-respect. All the United Nations and their Allies have pledged themselves again and again to free their peoples from want. The very core of this policy is a policy of Social Security. In this year's presidential message, freedom from want and the right to earn a living were again solemnly affirmed. The world is potentially so wealthy that poverty and disease, squalor and ignorance, are no more natural or tolerable to us than slavery. As mankind threw off slavery, so it can throw off these evils.

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After the last war enormous changes occurred in Europe and in twenty years great reforms had established a splendid, if incomplete, system of social services—agrarian reform, housing, unemployment insurance, pensions for dependents, workmen's compensation, state medical schemes, etc., which were a safeguard to many millions. In the United States of America such reforms were retarded by fictitious prosperity and opposition ideas until 1933. From 1933 large majorities of American citizens realized that Security was a fundamental necessity of a modern economy and that it is better for democracy and for steady progress to have the assurance of this than to have the possibility of great fortunes and dazzling careers—for a few.

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It is certain that when the world returns to normality it will not be the normality of the old kind but a new normality. What that normality of the future shall be lies in our hands. The danger for the future will be a belief that it can be exactly like the past. The slogan for the future which every sincere and genuine well-wisher of modern government must express is 'Do not fear your government! Do not be afraid of, first, trusting it with responsibilities and authority to regulate certain sections of social and economic life, and secondly, do not be afraid of your own capacity to control and direct that government so that it remains responsible to the common man.' Every country is interested in high living standards in other countries to reduce unfair competition and to raise production everywhere. This implies world-wide establishment of Social Security systems.

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The content of social action and planning for the twentieth century comprises at least four matters.

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*Presented under the auspices of the Providence Council of Social Agencies, at Providence, February 3, 1944.

First, a high level of prosperity and living standards; secondly, the assurance of each man and woman of a secure position in that prosperous system; thirdly, social provision for individual misfortunes and the levelling up of opportunity. This program alone will give civic equity as a contribution to real democracy.

* * * * *

A high level of prosperity will require, and there is no doubt whatever about it, that the state shall cooperate with management and labor and other social organizations to secure: full employment (which may involve public works, the retraining and rehabilitation of those who have lost employment); the development of resources; changes in the taxation system to encourage consumption and to release capital; the further development of state-provided or guaranteed credit; good labor conditions inside the workshop and the utmost use of science and inventions now available to mankind and especially a policy in agriculture favoring changes in the quantity and quality of diet available universally.

This program—making for and standing upon the basis of full employment—is the foundation of the decent society of the twentieth century. It is the fundamental of fundamentals. It has been shown by Sir William Beveridge that to a proper Social Security system employment *must* be kept down and below, if possible, to 8½% of the occupied.

* * * * *

A secure position in a system of full employment must rest upon provision for dealing with great depressions; and then the hazards and changes of a fall in foreign markets; a change in domestic markets; changes in fashion and changes in technology—for example, the mechanization of hitherto unmechanized industries. Hazards of this kind have nothing whatever to do with a fault in the character of the worker. They are his misfortune and when they come, he and his family have to take it. But they are a direct product of the nature of modern industry. If we are to admit progress and elasticity, such misfortunes will come. The least that society owes one to another is provision for such predictable misfortunes. To provide for times of depressions, reserves of money and public works must be built up and this implies international cooperation also.

* * * * *

The provision is to be found partly in direct social services and partly in a system of social insurance. Social insurance can operate cheaply, effectively and reliably where the state organizes and coordinates. It must rest as the Wagner Bill and other plans have suggested upon (1) every citizen being included to provide the fund; (2) reasonable standards of security in the services provided; and (3) the method of insurance which gives every man and woman a right for which they have paid and which therefore does not subject them to the indignity of a means test.

* * * * *

The levelling up of opportunity implies that no part of the country shall be without a minimum standard of education for all who dwell in America; that housing shall be sufficient in quantity and quality to give a sense of Security and home and steadiness and self-respect to every American family; and provision of health services to each family so that there may be, if possible, attention paid to the increased vigor of the population rather than to the merely curative aspects of sickness which as Governor McGrath clearly showed in his Annual Message has caused a loss of earning power and a drain upon public assistance or employment funds. Social Security raises human welfare because it raises consumer demand and steadies purchasing power. It also makes people more vigorous in body and mind and production, and adapts it for work.

* * * * *

It is idle to believe that the prosperity of America, or any of the forty-eight states of America, is isolated from the prosperity of the whole world. America needs to import large quantities of foreign products. We may merely mention rubber, coffee, tea, silk, tropical medicines, spices, woods, nickel, cobalt, sisal, hemp, etc. America had about two thousand branch factories in other lands before the war. But even more urgent than this is the fact that even in the worst years before the war, American exports in seven classes of industrial products ranged from 40% of the total American production (copper) to 3.3% of the total iron and steel produced. In a bad year, America was exporting more than a half of its total production of cotton, more than a third of its copper and tobacco, more than a fifth of its wheat and flour; more than one-eighth of its refined oil, more than a quarter of the agricultural machinery, produced one out of every eight cars, one-third of the lard produced, one-fifth of the fruits grown, one-sixteenth of its

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SOME POINTS IN THE LABORATORY DIAGNOSIS OF MALARIA IN THE CHINA - INDIA - BURMA THEATER

Irving A. Beck, Capt. M. C., 48th Evacuation Hospital

It is superfluous to call to the attention of medical officers in this theater the importance of early and accurate diagnosis of malaria by the laboratory demonstration of the parasites. The cycle, morphology, and usual laboratory techniques are well covered in the texts of tropical medicine, generally available in this area e. g. *Manson-Bahr, Stitt & Strong, Rogers & Megaw*, the laboratory texts e. g. *Todd & Sanford, Craig & Faust, Stitt, Clough & Clough,* or in TM 8-227 "Methods for Laboratory Technicians". The "Manual for the Microscopical Diagnosis of Malaria in Man" (National Institute of Health Bulletin No. 180) available from the Superintendent of Documents, Washington, D. C., is an excellent well-illustrated brochure with especial emphasis on the thick drop method.

The following represents some points of value, observed or devised, with regard to special conditions encountered in this theater. It is not intended to be a complete treatise on the subject of parasite examination. Originality is not claimed, as many of the facts have been learned from indivuals of long experience in malarial diagnosis in this theater.

I. Methods

The recommended technique is the combined thick drop - thin smear stained with aqueous Giemsa. This has the advantage of the thick drop affording rapid diagnosis, and the thin smear serving for species identification (where this cannot be made by thick drop alone), and for differential white cell counts. In addition, the spirochete of relapsing fever, and microfilariae, can be readily detected on the thick drop.

Blood is taken by skin puncture, preferably from the finger. A bard-Parker scalpel blade embedded in a cork makes an excellent lancet. It is important to wipe the skin free of alcohol before taking the drop to avoid fixation of the thick drop. Two drops of blood are taken on a clean glass slide, which has been kept in 95% alcohol until just before use, and dried by polishing with gauze. One drop, slightly larger than that usually collected for an ordinary smear, is taken on the first quarter of the slide, and a second—the usual sized drop—at the midpoint. The latter is then smeared distally with the edge of another glass slide in the usual fashion. The first drop is then evened out to the size of a dime by making a series of widening concentric circles in it with the corner of another slide. If a small tangential "tail" is left, it will take care of the excess liquid. A wax pencil line is drawn across the slide between the thick drop and thin smear, and an identifying mark written on the free space at the thick drop end of the slide. It is desirable to have this checked by also scratching the mark with the point of a lead pencil on the thin smear.

The slide is allowed to dry in an horizontal position. Drying affords considerable difficulty in the extremely humid climate of India. These expedients were found useful. In the field, slides can be left in the direct sunlight, supplemented by fanning to hasten the process and to keep insects away. If a laboratory is available, the following "drier" can be easily made. The copper sterilizer, a standard item in the field medical chest, is partly filled with water and put into a wooden box the top of which has been replaced by the enamel instrument tray, also found in field medical equipment. Wire or glass rods, or bamboo across the tray hold the slides horizontally. The heat, generated by steam from the sterilizer, when the water is just simmering, is optimum for drying the blood in a few minutes. Overheating should be avoided as it will fix the thick drop, and prevent laking of the blood subsequently.

Another method is to replace the burner of a field kitchen range with an ordinary kerosene lantern. If the range is kept tightly closed there will be no difficulty in maintaining the level of body temperature in the container. This drier has the advantage of keeping the slides dry until the technician is ready to stain them. This is a necessity the writer has encountered at times when the atmosphere has been so humid that the dried blood promptly reabsorbed moisture. Parenthetically, this device also serves to keep film, cameras, matches, envelopes, and similar material dry and mold-free. When only a single slide is to be stained, it can be rapidly dried by rubbing the free

continued on next page

surface vigorously for a minute or two on the ball of the thumb.

As anyone knows, who has awakened to find his shoes green with mold in a single night, the air in certain localities is permeated with spores of fungi. These, and air-borne bacteria, find the blood film an ideal culture medium. Growth of these organisms has been observed in one locality in as short a period as one hour from the taking of the smear. If allowed to go on long enough, the smear will be ruined, and even in a short period, confusing artefacts will result. The remedy, under these circumstances, is prompt staining as this deters growth. Thick drops stain best when some hours old, but this advantage may have to be sacrificed where mold is a problem. It is important to keep the slides in a box or album, or covered with an inverted Petrie dish, while awaiting examination. Growth of mold will take place even on stained blood, and similar precautions should be taken if these are to be saved for reference.

The thin smear portion of the slide is fixed by a rapid dip up to the transverse wax line in absolute methyl alcohol. With this technique the fixing fluid is good (except for evaporation) almost indefinitely, and can be saved by repouring into another (not the original) bottle and reusing. This reagent has on occasion proved difficult to obtain here, so conservation is important. The fixed smear is then dried by one of the above methods.

Giemsa stain, as it has been supplied here, has been in the form of the powder, 1.0 gram per bottle. It has been found by actual weighing generally to contain somewhat more than this—possibly due to hygroscopic action once the bottle has been opened. The label provides the directions for the preparation of the stock stain. One step is the dissolving of the powder in neutral glycerin by warming at a temperature of 55-60°C. Where a waterbath is not available the following method may be used. A glass flask, beaker, or cleaned preserve jar, is partially immersed in the field sterilizer, above mentioned. One of the alcohol burners is lit, and the temperature controlled by a thermometer (a bath one will do), or the temperature of the water may be gauged by the finger—by heating to a slightly more than comfortable warmth. Where opaque bottles for the storage of the stock stain are not available, an ordinary one may be made light-proof by swathing it with adhesive tape.

The principle of the stain is that the dilute aqueous solution of Giemsa will lake the red cells of the unfixed thick drop, and simultaneously stain the unlaked elements—the parasites, white cells, and platelets. The thin smear, being fixed, has the customary appearance. The dilute aqueous solution, about 2.5 cc. of which is used per slide, is made up fresh each time by adding stock stain in the ratio of one drop to each cc. of distilled water, or filtered rainwater. The dilute stain is then droppered onto the slides on a rack. The usual staining time is 30 minutes. It will be found, however, that the degree of dilution and the length of staining will vary somewhat with each batch of stain, and with the age of the stock stain. Some experimentation will be necessary to determine the optimum in each instance. The stain is gently rinsed off with distilled water, if available, but when not, well or rainwater has been found satisfactory.

If Giemsa is not available, Wright's stain may be substituted by diluting it 30 times with distilled water, and staining as above. It stains much more erratically than Giemsa, and the parasites on the thick drop are not as well defined.

A difficulty occasionally encountered with the stained thick drop is the tendency of the stain on occasion to fade rapidly. This affects chiefly the cytoplasm, so that sometimes in 12 hours all but the chromatin masses will have disappeared. If the reagents, including the immersion oil, are all neutral, the reason may lie in excessive atmospheric humidity. The fading may be remedied to a certain extent by increasing the concentration of the dilute stain.

The thick drop examination affords at least a 20:1 time saving ration over the thin smear. This advantage makes its use almost mandatory where large numbers of slides have to be examined with limited technical help, or where parasites in the peripheral blood are scanty as in P. Falciparum infections, or where suppressive therapy has been administered. Distortion of parasite morphology does however take place in the process of thick drop staining, and a knowledge of these variations is essential. Once acquired, examination of thick drops is an easy matter, and rarely does the thin smear have to be consulted for species confirmation.

Cedar oil for the immersion lens may not always be available. Ordinary medicinal mineral oil serves just as well. The 5X or 6X ocular lens is used initially, and when a suspicious form has been located more minute examination is done with the 10X ocular.

II. Examination

The *Bulletin No. 180 of the National Institute of Health* previously referred to has excellent descriptions and illustrations of the parasites as they appear on the thick drop. Most of the standard texts contain little on the subject. The following observations may, therefore, prove useful.

Examination of 50 oil immersion fields can be done in 2-3 minutes by an experienced technician, and nearly 100% of clinical infections will be detected in that number. In survey work, or where visceral malaria is suspected 100 fields is advised.

Ring forms—These, particularly, are apt to be distorted on the thick drop. The usual distortion forms assumed are due to interruption, fragmentation, or clumping of the cytoplasmic ring. This may cause the parasite to assume a "swallow" form,—a central chromatin dot with "wings" of cytoplasm; or an "exclamation point" form; or a "parachute" type—this being the result of the cytoplasm flaring out from the chromatin dot. This "parachute" type has been found most frequently with P. Falciparum, and assists in the species diagnosis.

Older trophozoites—Those of P. Falciparum are generally not present in the peripheral blood, but it is well to remember that they may be found in severe infections, and in chronic cases in hyperendemic zones. Their thick film appearance is as small compact clumps of cytoplasm attached to one or two dark blurred masses of pigment. Due to the latter, confusion with P. Malariae is possible. With P. Vivax, the Schueffner's dots are generally not apparent, but it has been noted that the remains of the red cell parasitized by P. Vivax persists as swollen, pinkish granular material, sometimes reticular. If this red cell "shadow" is definitely enlarged, the organism is always P. Vivax. P. Malariae in this stage often appears as a round compact heavily pigmented mass of cytoplasm with a small chromatin dot. One does occasionally see the typical band forms.

Schizonts—These appear the same as on the thin smear save that their outlines may be distorted, and the size shrunken.

Gametocytes—Differentiation of the gametocytes of P. Vivax and P. Malariae from each other, or from mature trophozoites with undivided chromatin of any species, is often quite difficult, and several forms may have to be studied before arriving at an opinion. The granular, enlarged red cell "shadow" may indicate P. Vivax as with the trophozoite. With P. Falciparum the gametocyte may have its characteristic crescent shape, but it may "round-up" to an ovoid form.

There are slight variations in different localities in the morphology of the same species. Thus it has been noted that in one area of Northeast Assam, P. Falciparum rings may resemble those of Vivax in having an irregularity due to tiny pseudopodial processes. In a new locality, there should be frequent checks with the parasites' appearance on the thin smear. These strain variations can be acquired only by experience.

Summary

A number of points of value in the technique of the staining process, and in the examination of stained malarial parasites, have been presented. The significant distortions found in the recommended thick-drop method have been described.

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STATE VOLUNTARY ADVISORY COUNCIL ON HEALTH

On February 5 Governor J. Howard McGrath activated a 35-member State Voluntary Advisory Council on Health to carry out the proposal made by Dr. Emery M. Porter, past president of the Providence Medical Association, that an overall survey of the health facilities and needs of the State be made by a statewide, non-partisan, representative council.

Dr. Porter's plan, as published in the JOURNAL last month, called for the creation of a 25-member Council by the State Medical Society. This plan was endorsed by the Council of the R. I. Medical Society and subsequently submitted to the House of Delegates for action. The latter body approved of the proposal, but acquiesced in allowing the Governor, who had expressed his desire to do so, to appoint the Council. Using Dr. Porter's outline as a working blueprint the Governor has enlarged the list to include representatives of insurance, the veterans, pharmacy and osteopathy.

In its initial meeting the Council organized to the extent of adopting the Governor's suggestion that the Chairman of the new Council be the President of the Rhode Island Medical Society, the vice-chairman the President-elect of the same Society, and the secretary the representative of the department of Social Welfare. Adopting this suggestion the new Council elected Dr. Michael H. Sullivan, Dr. Elihu S. Wing, and Mr. Glen Leet as its officers, and then proceded to elect Governor McGrath as its honorary chairman.

Expressing the hope that the Council would give consideration in the immediate future to his proposal for a compulsory hospitalization, Governor McGrath recommended the appointment of technical sub-committees within the Council to consider various problems, and a motion was adopted that the Chairman be empowered to appoint all committees he deems advisable.

As named by the Governor the new Council on Health has eleven doctors of medicine, including the State Director of Health and one doctor representing the State Hospital Association; a dentist; a nurse; an osteopathic physician; two representatives of veterans' organizations; two representatives of organized labor; two representatives of industry; three insurance representatives, one of Blue Cross, one of private insurance and one the state director of insurance; two representatives of social agencies; two attorneys at law; one representative of pharmacy; two representatives of the state department of Social Welfare; and five representatives of the public generally, including two clergymen, a banker and an executive secretary.

The complete roster of the Council is as follows:

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MALARIA IN RHODE ISLAND

One of the major keys to our success in the war in the Pacific lies in the medical research for the solution of a preventive of malaria which has hindered our forces far more than the Japs. The search for the answer is going forward night and day in the scientific laboratories of America, and the study of tropical diseases has received tremendous impetus in every medical college of the country. Until the answer to malaria is found the control of the sources of infection offers the major preventive aid.

Therefore the current publicity given to the imperative need for mosquito control here in Rhode Island to avoid the possibility of a malaria epidemic strikes closely at the heart of a problem that is international in scope. Doctors everywhere are fully cognizant of the fact that it is going to be necessary for every physician to have a working knowledge of malaria and other tropical diseases in the years ahead when millions of service men return from tropical duty to civilian life. But for our comunities to ignore the local control of mosquito breeding is to jeopardize the health of the citizens to an extent that is entirely inexcusable.

The species of anopheline mosquito that is responsible for the transmissions of malaria is a normal inhabitant of southern New England and twenty five years ago malaria was frequently seen in this State. Due mainly to the fact that the mosquito was considered a pest rather than a health menace, control of breeding places was initiated effectively in 1936, with Greater Providence making more progress in the work than the outside communities. There are six known breeding places of the anopheline mosquito in the Providence area, and in 1943 no mosquitoes of this type were found. At the present time a small group of men in Providence are doing a good job in spraying 10,400 catch basins and 146 breeding areas eight times a year. But all this work in the Providence area will not prevent the spread of malaria from other parts of the State where the control program has been allowed to lapse.

Likewise, the new threat of malaria within our civilian ranks should result in an increased appropriation by Providence to further the mosquito control project. In 1936 the City of Providence sponsored a $250,000 WPA project, taking in the surrounding territory in the control of mosquito breeding. In 1937 a sum of $342,000 was available for the project; in 1938, $279,152; and in 1939, $230,690. Then in 1940 WPA dropped out and SUR took over the program under state and city

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sponsorship and $23,000 was made available that year, $18,000 in 1941, and $10,000 in 1942. Last year the City of Providence accepted the responsibility of the work and until the first of October had expended approximately $6,200.

Probably no great sum need be established to continue the work in Greater Providence where the breeding places are known and marked. But certainly any money that may be spent in this work, by the City or the State, would be insignificant compared with the economic loss associated with treating malaria itself, while even more important is the prevention of human suffering from the disease. A statewide study is imperative at this time to discover any breeding places of the anopheline mosquito. Perhaps there are only a few such areas, and in that case the work of control would be simplified, and the threat of epidemic malaria minimized.

THOUGHTS AFTER READING DR. FINER'S ADDRESS

Time was when the pages of this Journal were given up almost entirely to scientific papers. Our members chiefly, and occasionally medical men from other communities, tried to advance the healing art by telling of their experiences and the conclusions they drew. Most of it probably was not highly important but some was, and the mass product represented an altruistic work for ailing humanity.

There has come a great change. Such papers are fewer and are much less elaborate. The younger men who contributed the bulk of the work are now at war and those left behind are overworked with routine duties. They just have not the time or energy to prepare extensive articles. Besides the war literature undoubtedly the most interesting and outstanding articles have been concerned with medical economics and sociology.

Of course this has been forced upon us. From all sides we are being served notice that we must change our ways of practice and our relations to our patients. The cash sickness act has made us busy filling out papers at weekly intervals, the Governor is going to revolutionize the hospital situation through the legislature and Senator Wagner is frankly going to socialize medicine.

It is all rather disturbing to those of us who feel that in a fallible and sinning world medicine has been conducted on as high a plane as any human endeavor and that precipitate change is rarely progress.

Perhaps it may be somewhat consoling to realize that we are not adrift alone on our raft in this sea of perplexities. We are in the same boat with many others, although somehow we do seem to be the most conspicuous of the castaways.

On another page is a summary of an address before the Council of Social Agencies. The Honorary Sponsors are people who have done exceedingly well for themselves in the competitive society in which to the present we have lived.

The address tells in no uncertain terms what the speaker believes the new order is going to be. If you like it you will call it socialism; those who don't may call it bureaucracy.

Apparently we are merely the first group where the shift is being made.

WAR AND EPIDEMICS

One of the big stories of this war is the story of what American medical men and their staffs have done to prevent the spread of epidemics among our armed forces in the Middle East. It is almost incredible.

Throughout history epidemics have periodically swept over these very areas destroying millions of lives, ravaging and defeating armies, changing the very course of history. Far more men have been lost in these epidemics than have been killed and wounded in battle.

Between 1919 and 1921 three million Russians died of typhus. Malaria and dysentery ravaged the Mediterranean armies of both sides during the first World War. Influenza took a high toll.

Yet there hasn't been a single epidemic of any of these devastating diseases among our forces in the Middle East, which are spread over an area of some ten million square miles. Though typhus has broken out among the civilian population there, no cases have been reported among our soldiers.

There was an outbreak of bubonic plague—"Black Death"—several months ago in West Africa. There wasn't a case among the soldiers in this area. There have been cases of malaria but nothing at all comparable to the cases in other wars. It is, as we say, an almost incredible story.

But there is the record. Someday it will be spread out in full for Americans to read, and to marvel at, and to thank a brilliant, indefatigable medical staff for having written.

. . . *Reprinted from The Providence Evening Bulletin, January 3, 1944.*

COMPULSORY HOSPITALIZATION II

The appointment by the Governor of a 35-member State Voluntary Council on Health should mark a significant forward step in community planning of health problems. The representation is all-inclusive, and from the solid thinking of such substantial citizens should flow some worth-while proposals.

One thing that disturbs us, however, is the fact that the new Council has been characterized by the public press as a group named to study the question of compulsory hospital insurance and related subjects. On the contrary it is our belief that the Council, if it is based on the pattern set forth by the State Medical Society which sponsored the plan as made by Dr. Emery M. Porter, would be concerned with a careful survey of the medical and health facilities and needs of the people of the State, for the purpose of recommending the coordination of present programs with any new plans whereby the medical and hospital needs of every citizen may be met.

The Governor has proposed a compulsory hospitalization insurance law, and it is fitting that the new Council concern itself with that problem. But we advance the belief that the hospital problem is not a distinct one that can be treated alone. Its ramifications, as pointed out in these columns last month, are many, and unless a complete exploration of all the facilities of the State and the needs of the people is made, the compulsory legislation might well defeat the purpose for which it is proposed.

It is significant that the original proposal made six weeks ago has yet to be publicly endorsed by any hospital, even in principle, nor has any board of trustees of any hospital given any indication that the enactment of compulsory hospitalization legislation will encourage them to expand their present facilities. On the other hand, we note with much interest that the cities of Cranston and Warwick look with favor upon the possibility of hospitals within their city limits, and the creation of such institutions in these areas would certainly have a corresponding effect upon the demands for hospital accommodations in the Providence district. Likewise, acceptance of the proposal of the Welfare Commission whereby the State Infirmary would be made a State General Hospital, making available several hundred beds for acutely ill patients, would further complicate the issue.

Thus the problem might become one of wider distribution of hospital facilities throughout the State, with the towns of Bristol County cooperating to establish a hospital in East Providence, Cranston fulfilling its plan now under consideration by the City Plan Commission, and Warwick taking the leadership in the Kent County area. Such hospitals might be financed by city and town bond issues, and staffed in the beginning with doctors from the Providence area augmenting the local physicians resident in each district. Undoubtedly this situation, as well as the possibility of a Veterans Facility in Rhode Island, will receive thorough study by the technical committee of the new Council.

Of vital importance, however, to the approach to the universal hospitalization recommendation is the need for a complete analysis and evaluation of the existing facilities. At the present time hospitals are being utilized to near capacity, certainly as regards private and semi-private accommodations, but all the factors contributing to the present situation must be carefully studied to decide whether or not the problem is to be a permanent one.

We can think of several questions that must be answered in reaching conclusions on the present demand for hospital accommodations. We have had an unprecedented increase in births the past two years; migratory workers attracted to this State for defense work have swelled our population; the industrial accident rate has increased alarmingly, due in sizable measure to the increased work tempo created by war needs, plus the rapid transfer of unskilled workers to skill trades; the Naval hospitals are fully utilized for Service personnel, thus making it necessary that dependents of Navy men be hospitalized at private institutions; we have had a slight flu epidemic; and undoubtedly the doctor and nurse shortage has prompted the hospitalization of many persons who in normal times would be attended at home.

These situations are attendant in no small measure upon the war, and their elimination in peacetime would change the hospitalization picture materially. Undoubtedly there would still be need for additional facilities, but such requirements should be predicated on the actual or anticipated demands for the better health care of the individual, and not on a theoretical assumption of economic difficulties that may face the private hospitals of the State.

"UNITED WE STAND - - -"

Now it is the A.A.P.S. that we are asked to join!

In other words, a proposal for an Association of American Physicians and Surgeons has been initiated by the Lake County (Indiana) Medical Society as the latest panacea for counteracting the threats of federal control of medicine, and as a supplement to the work of the American Medical Association.

According to its issuing statement sent to all the doctors of the country the A.A.P.S. is reported to be on sound legal foundation. That is something in its favor. We question, however, that it is predicated on a sound foundation as regards the solution of the better organization of American medicine. The proposal of the Lake County physicians may be a noble gesture, but we fail to see that it is a sensible approach to what appears to be the problem of the day.

In the first instance the new organization merely adds to the disunity of medical organization, and it stands as a rebuke to the American Medical Association. But is this the way to correct any existing faults? Would it not be far more profitable to all concerned if the Lake County enthusiasm were directed towards a stronger representation from each state to the House of Delegates of the AMA that the "grass roots of American medicine", as the A.A.P.S. speaks of its representation, will be more vociferous and more effective in shaping the administrative policies of organized medicine?

Every national organization has faults when viewed from the sectional and the State level, and the American Medical Association is no exception. But the Washington idea of conflicting committees and sub-committees until the alphabetical abbreviations are exhausted should not be copied as we seek to answer our problems. We have a Committee of Physicians for the Improvement of Medical Care, Inc., and then along came the National Physicians Committee for the Extension of Medical Service, the NPC as it is now familiarly known. Now the A.A.P.S. invades the field of duplicating agencies in the field of medical economics and medical public relations.

The American Medical Association is the only national organization that has our support. If it errs in its administration, then ours is the responsibility to express our views freely and frankly. It has probably been the failure of the State medical societies to instruct properly their delegates, and the subsequent failure of the delegates clearly to enforce the viewpoint of the majority of the profession that has contributed to the misunderstandings and conflicts in opinions that have been rampant throughout the profession relative to the parent organization. The remedy is apparent, and it is not the creation of new associations.

TOMORROW'S LEADERS

War as waged today, with even the press and the radio contributing immeasurably to the quest for victory, is a far cry from all previous conflicts between nations. And in the maelstom of adult activity which absorbs our every waking hour we have suddenly discovered that children go to war too, for they are conscious of all its ramifications through radio reports which speak into every home, and even through their own press—the comic pages —which has assumed new warlike hues to stir the imagination of even the smallest child.

The sudden awakening to the fact that these leaders of tomorrow's world are so closely indoctrinated in the problems of war has been a cause for widespread alarm in many communities. The possibility of the development of mental defects due to war excitement which may lead to delinquent behavior is voiced, and problem of juvenile delinquency in all its ramifications has brought forth demands for curfews, supervised recreation, stronger parental guidance, and more diversified community activities to meet the problems of war children.

It is at such a time that we evaluate anew the great contribution of voluntary youth building organizations such as the Boy Scouts of America. It is then that we realize once more that Scouting's programs best utilize the energies and enthusiasms of our boys to meet the emotional, and to some extent the environmental problems which face them at all times. The campaign, therefore, launched this month for 1,000 more Scout Units in 1944 in New England warrants the support of all citizens as it offers an outstanding answer to the need for strong leaders in the years ahead to preserve our national ideals.

BUY WAR BONDS

RHODE ISLAND STATE DENTAL SOCIETY

ARTHUR M. DRING, D.M.D., *President*
EARL B. KEIGHLEY, D.M.D., *President-Elect*
WILLIAM S. GEE, D.M.D., *Vice President*
CHARLES F. MCKIVERGAN, D.M.D., *Secretary*
JAMES C. KRASNOFF, D.M.D., *Treasurer*
HAROLD F. DOYLE, D.M.D., *Librarian-Curator*
NORMAN H. FORTIER, D.M.D., *Editor*

NEW PRESIDENT OF SOCIETY

Dr. Arthur M. Dring of Newport, elected as the President of the Rhode Island State Dental Society for 1944, is one of the most active members of the profession in the State, and under his leadership the Society should enjoy a very successful and progressive year.

A native of Newport where he received his elementary and high school education, Dr. Dring was graduated from Tufts College Dental School in 1924. He served a dental internship at Rhode Island Hospital during 1924-25, and in the latter year he returned to his home city to start the practice of dentistry. He has been secretary and treasurer of the Newport Dental Society, and last year he was named as president-elect of the State Society. He is also a member of the American Dental Association.

BOARD OF TRUSTEES — 1944

DR. RONALD C. DOVE of Westerly
DR. GEORGE J. RACICOT of West Warwick
DR. PAUL E. COTE of Woonsocket
DR. FIMON OZARIN of Newport
DR. DONALD D. OSBORN of Providence
DR. WILLIAM A. MORINVILLE of Pawtucket
DR. ARTHUR JOHNSTON of Warren
MR. MAURICE A. DENBY of Warren
DR. ARCHIE A. ALBERT (*Representing the Board of Dental Examiners*)

DR. CLUNE ON HEALTH COUNCIL

Dr. Thomas W. Clune, past president of the Society, is our representative on the 35-member State Voluntary Council on Health appointed by the Governor to study health needs for the people of Rhode Island.

Necrology

DR. JOHN B. LAFLAMME of Pawtucket . . .

Died, January 22, 1944

HORACE WELLS CENTENARY COMMITTEE

One of the final acts of out-going President Maurice A. Denby was the appointment of Dr. Edward C. Morin of Pawtucket as Chairman of the Horace Wells Centenary Committee.

It was Horace Wells, a dentist, who on December 11, 1844, demonstrated to the world that relief from pain was possible by inhaling nitrous oxide gas. Since then surgery has advanced to undreamed of heights through the application of anesthesia to millions of people. As a result every dentist should thrill with pride at the mention of the name of Horace Wells for this contribution, and the new committee to prepare the centenary program should receive the full support of all of us.



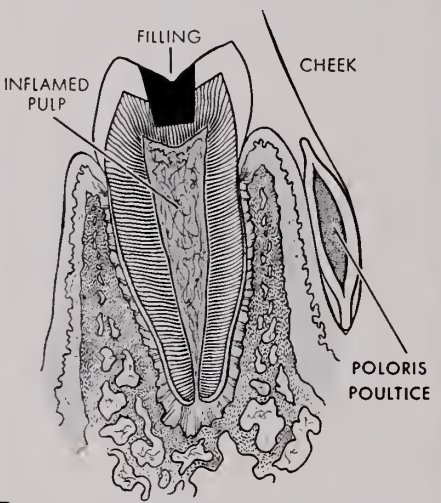
ARTHUR M. DRING, D.M.D.
of Newport, R. I.
President of the Rhode Island State Dental Society for 1944

Treat Pain LOCALLY with COUNTER-IRRITATION

Counter-irritation stimulates capillary activity, allowing blood to flow more freely through congested tissue, thus relieving pain, accelerating reparative processes and producing better end results.

In the treatment of Post-filling Sensitivity, Poloris Dental Counter-Irritant is preferred by many dentists to the systemic treatment of pain with internally taken drugs. Poloris is also indicated in cases of pericementitis, abscess, gum inflammation, post-extraction pain and "telephone-treatment" of emergency dental pain.

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Counter-irritating action of Poloris Poultice on sensory nerve endings in gum tissue stimulates capillary activity, causes relaxation of the congestive hyperemia in the dental pulp.

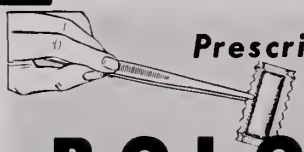


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Prescribe

POLORIS

For Prompt Pain Relief

DENTAL COUNTER-IRRITANT

POST WAR PLANNING and SOCIAL ACTION

continued from page 64

electrical equipment. Millions of American workers and families are dependent upon the mass production making possible these exports and necessitating them for a high national income for Americans.

* * * * *

Therefore full employment in America is to be had only if America is a full and free unit in the great economy of the whole wide world. Therefore, any measures required in the postwar development abroad of industry and agriculture on a cooperative basis with America is part and parcel of the American economic Social Security program. There is no way out of this conclusion, and it is happy to think that American statesmen have recognized this.

* * * * *

All this puts a heavy weight of responsibility on the modern citizen. The producer must be alert, enterprising, hardworking and ready to transfer from one industry to another, from one job to another, to adapt himself. He must not rely upon monopolies. Secondly, the citizen as a saver has the responsibility of regularly providing week by week his percentage of the pay roll for the Social Security funds—he must, therefore, be in steady work and put in a hard week's work. It is an abysmal error to believe that initiative and the spirit of adventure, as Sir William Beveridge has pointed out, are the products of poverty, ignorance and disease. Initiative and the spirit of adventure do not arise from fear and insecurity, but out of a healthy body and mind. Thirdly, the professional men, like the doctors, who will come to serve their patients through social organizations, whether of the state or such organizations as the Blue Cross, will have to maintain that same noble sense of individual responsibility as they would when working directly for the fee of their own patient; and finally, the increased numbers of social workers in all the Social Security agencies will have to develop and maintain a most sensitive responsiveness to and solicitude for the welfare of those who come to them for some form of income maintenance to which they are entitled by the law of the land. It is an immense responsibility on the part of all—but that is the price which must be paid if there is to be simultaneously an increase in the standard of living and an increase in the Security of all. If what I have said needed to be put in one sentence, it could be put in an ancient and beautiful one: "Love thy neighbor as thyself".

VOLUNTARY HEALTH COUNCIL

continued from page 68

Edward A. McLaughlin, Doctor of Medicine, State Director of Health, Residence: Providence, R. I.

Eugene U. Messier, State Department Commander, Veterans of Foreign Wars, Residence: Central Falls, R. I.

Cornelius C. Moore, Attorney at Law, Residence: Newport, R. I.

Alexander Pausley, Doctor of Osteopathy, Residence: Providence, R. I.

Herman C. Pitts, Doctor of Medicine, Chairman, Medical Economics Committee, Rhode Island Medical Society, Residence: Providence, R. I.

Dennett L. Richardson, Doctor of Medicine, President, Hospital Association of Rhode Island, Residence, Providence, R. I.

W. Henry Rivard, Doctor of Pharmacy, Dean, R. I. College of Pharmacy & Allied Sciences, Residence: Providence, R. I.

Arthur H. Ruggles, Doctor of Medicine, Superintendent, Butler Hospital, Residence: Providence, R. I.

Stanley H. Saunders, Executive Director, Hospital Service Corporation of Rhode Island, Residence: Providence, R. I.

Stanley Sprague, Doctor of Medicine, Residence: Pawtucket, R. I.

Michael H. Sullivan, Doctor of Medicine, President, R. I. Medical Society, Residence: Newport, R. I.

Harold B. Tanner, Attorney at Law, Residence: Providence, R. I.

Elihu S. Wing, Doctor of Medicine, President-elect, R. I. Medical Society, Residence: Providence, R. I.

George E. Withington, jr., Commander, American Legion, Department of Rhode Island, Residence, Providence, R. I.

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$5,000.00 accidental death $25.00 weekly indemnity, accident and sickness	For $32.00 per year
$10,000.00 accidental death $50.00 weekly indemnity, accident and sickness	For $64.00 per year
$15,000.00 accidental death $75.00 weekly indemnity, accident and sickness	For $96.00 per year

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41 Years Under the Same Management
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86c out of each $1.00 gross income used for members' benefit
Disability need not be incurred in line of duty—benefits from the beginning day of disability.

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A HURDLE TO HEALTH ?

There is no necessity for a denture wearer to suffer embarrassment, nervousness and poor digestion resulting from insufficient mastication due to loose, ill-fitting dentures.*

Dr. Wernet's Plate Powder sprinkled on dentures holds them securely and comfortably in place —cushions the shock of biting and chewing and thereby helps to restore confidence and the ability to masticate all types of food properly.

Made of costliest ingredient— so pure you eat it in ice cream— Dr. Wernet's Powder is pleasant tasting, harmless if swallowed, and safe to use regularly. Recommended by dentists for over 30 years. A sample will be sent on request or it is available in regular sizes at all drug stores. For free sample, address: Wernet Dental Manufacturing Co., Dept. 164-B, 190 Baldwin Avenue, Jersey City 6, New Jersey.



Loose, ill-fitting dentures are usually the result of changed bone and tissue formation. In severe cases the patient should, of course, see his dentist.

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Holds dentures firmly and comfortably in place



FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street Providence

NEW FELLOWS OF THE SOCIETY

The number of Fellows enrolled as active members of the Society continues to grow, marking the highest enrollment in the history of our organization. The following became Fellows within the past two months: Drs. Ada D. Bedinger, Lewis T. Bennett, Marco Colagiovanni, Bruno DeFusco, Eugene A. Field, Pio Giannini, Nora P. Gillis, John I. Pinckney, Arthur Rattenni, E. Franklin Stone, and Daniel D. Young, all of Providence; Drs. Edward F. Dougherty and John Vallone of Cranston; Dr. Katharine K. Cutts of East Providence; Dr. Bernard B. Seltzer of Cranston (now on active duty with the army); and Dr. Jeannette Vidal of West Warwick.

AT THE "CROSSROADS OF AMERICA"

The Indiana State Medical Society signally honored our executive secretary last month by placing him on the program of its 19th annual Secretaries' Conference held at Indianapolis on January 23. Mr. Farrell spoke to the topics "The Rhode Island Cash Sickness Act, and Public Relation in the New England States". On the same program were Clarence Jackson general manager of the Indiana State Chamber of Commerce, Dr. W. Norwood Brigance, professor of speech at Wabash College, Dr. Charles N. Combs of Terre Haute, Dr. L. Fernald Foster, secretary of the Michigan Medical Society, and William J. Burns of the same Society, J. W. Holloway, director of the Bureau of Legal Medicine of the AMA, and Dr. Edward J. McCormick, past president of the Ohio State Medical Association and now a member of the new Council on Medical Service and Public Relations of the AMA.

LIP READING CLASS FOR CHILDREN

The Providence League for the Hard of Hearing calls attention to its class in lip reading for children between the ages of 9 and 16 which is held at the League rooms, 42 Weybosset Street, Providence, on Saturday mornings at 10 o'clock. The class is free, and any children who might be benefited by the study of lip reading are welcome.

REGIONAL MEETING OF SURGEONS

A regional war session will be held by the American College of Surgeons at Springfield, Massachusetts, on Monday, March 20, for the medical profession of New England. The Springfield meeting will be one of 22 such meetings to be conducted throughout the country by the College during March and April. Each meeting will open at 8:30 a. m. with the showing of official Army and Navy films on medical and surgical subjects, such as evacuation of wounded, fractures, bomb blasts, burns, and treatment of wounds. Later in the morning session Army and Navy representatives who have been on active duty abroad will report, and members of the Public Health Service will report on measures for the control of endemic and epidemic diseases.

The afternoon program will consist of scientific presentations and will be climaxed with a dinner meeting at which a panel of experts will highlight the discussions of the day. The meeting at Springfield will be held at the Hotel Kimball and it will be open to the profession at large.

ON THESE PLANTATIONS

Dr. Joseph C. Johnston of Providence was recently elected president of the Friendly Sons of St. Patrick . . . Dr. James P. Deery addressed the Consumers' League of Rhode Island at its January meeting on the subject of "Industrial Health in Rhode Island" . . . Dr. Malcolm Winkler was elected a Diplomate of the American Board of Dermatology and Syphilology recently.

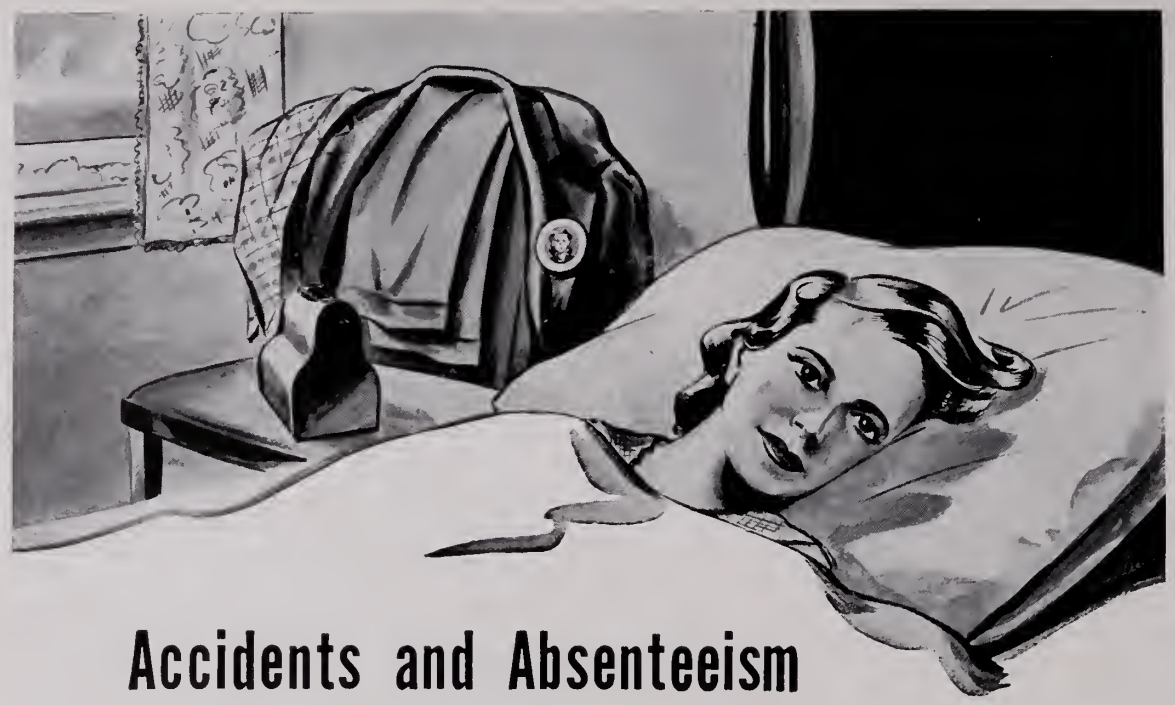
NECROLOGY

IRVING BLAZAR, M.D.
died December 20, 1943

THOMAS H. MURPHY, M.D.
died December 28, 1943

MICHAEL P. MAHONEY, M.D.
died January 21, 1944

GEORGE R. MANKIS, M.D.
died January 23, 1944



Accidents and Absenteeism

ACCIDENTS contribute to absenteeism. In women — particularly the conscientious middle-aged who try to stay on the job—the nervous symptoms associated with the menopause may directly affect their efficiency, and contribute to accidents of one kind or another.

For women in the menopause who require estrogenic therapy, the Squibb Laboratories supply *natural* estrogenic substance, Amniotin in Oil, and the *synthetic* estrogen, Diethylstilbestrol.

Physicians who prefer natural estrogens will find the vial packages of Amniotin in Oil very practical and economical. The three potencies which are available (20,000, 10,000 and 2,000 I.U. per cc.) offer a range suited to various patients. The vaccine-type cap permits the withdrawal of a dose of just the size to meet the patient's needs.

The lower cost and convenience of Squibb Diethylstilbestrol Tablets appeal to many busy physicians who are realizing more and more that the side effects of the synthetic estrogen are generally merely temporary, and that after a few days many patients gain tolerance to the drug so that they can take the tablets without discomfort and obtain the benefits afforded by oral administration.

Amniotin and Diethylstilbestrol Squibb are supplied in a variety of dosage forms for oral and hypodermic administration. Also in pessaries (vaginal suppositories).

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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., Chairman; Herbert E. Harris, M.D.; Stanley D. Davies, M.D.; Michael H. Sullivan, M.D.; William P. Buffum, M.D.

EMPLOYING THE PHYSICALLY HANDICAPPED

THE rapid expansion of industry, and the radical changes which are taking place in established industries, produce problems which are new in the field of Industrial Health. Chief among the problems is the employment of physically handicapped workers. Previously Medical Departments of our industrial establishments were anxious to employ only those who were physically free from chronic defects of any character, but changes in the composition of those individuals applying for work in mills and factories today force us to revise our standards of medical examination previous to employment in industry. This subject has been discussed in this column previously and some modification of the pre-employment technique was minutely described.

If industry is to succeed in maintaining production it must do so with a larger proportion of handicapped workers and, instead of scrapping our old standards of pre-employment physical requirements it is well to examine wherein they can be modified to meet the demands of the new type of limited or physically handicapped worker. There are many people who under ordinary circumstances would find it difficult to be employed, or who would be unacceptable to industry in normal times. Such people are those who have poor eyesight, diabetes, arrested tuberculosis, high blood pressure, heart ailments, arthritis and similar disorders. Possibly they may have skills needed in war plants. If so, they might be fitted into the organization with a little careful supervision on the part of the Medical Department.

As an example of what may be done, the Bendix Aviation Corporation established a plant in Chicago which is now the largest carburetor factory in the world, and in it they particularly tried to utilize every possible type of handicapped worker. Among the hundreds of unemployables who are working well and contentedly are a number of pituitary cases ranging from one man who is six feet, eight inches tall to another who measures four feet, six inches. A number of employees have partial atrophy of their arms or legs from infantile paralysis. People with high blood pressures do a normal day's work at jobs involving no physical strain. Men with hernias are doing jobs where no lifting is required, and workers with slight heart murmurs are given work where they can sit down part of the time. Employees with arrested tuberculosis work in dust-free rooms at jobs that are not too strenuous for them. Also a number of arthritics and people with deformed hands are given an opportunity to use keen eyesight on light inspection duty.

Of course, our standards at all times have been rather to place the worker in the proper job than to automatically reject him because of a defect. In normal times a pre-employment system protects the manufacturer against increased costs thru accidental injuries and thru absences due to illness. This is right and proper. Even in normal times there has been a tendency to accept as employees persons with handicaps that are not too severe or disabling. In unusual times such as these it is important for physicians in industry to examine the applicant with a view of trying to find some work that he can do even though he may have a severe or crippling disability.

It has been pointed out that the severely handicapped workers really are an asset to industry for several reasons. In the first place, they are usually draft-proof. They are usually grateful for the opportunity of employment and the labor turnover is thus reduced. In other words they stay on the job once placed there. What is most important of all, the handicapped worker has had to learn how to safeguard himself. He moves with more caution than the average worker, and in the main he is usually a more safe worker than a person not so

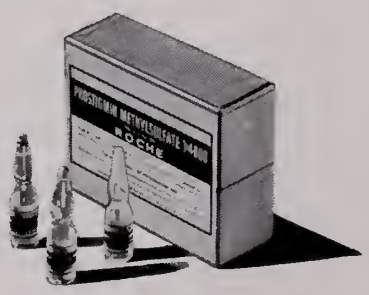
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— **POSTOPERATIVE DISTRESS** may mar the clinical picture to a discauraging degree. Abdaminal distentian and urinary retention, fallawing surgery, are frequently the cause of camplications necessitating traublesome pracedures that are apt to retard the patient's recovery. The rautine use. af Prastigmin Methylsulfate* 1:4000 provides a canvenient and effective means of preventing intestinal and bladder atony, minimizing the likelihood af "gas pains" and the need for catheterization. Try Prostigmin 'Rache' for a smoother, uninterrupted convalescence. Inject 1 cc (1:4000 solution) at the time af aperatian. Fallow with 5 similar 1-cc injectians at 2-haur intervals after the operation. HOFFMANN-LA ROCHE, INC. • ROCHE PARK • NUTLEY, N. J.

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PROSTIGMIN 'ROCHE'



EMPLOYING THE PHYSICALLY HANDICAPPED

continued from page 79

handicapped. In fact, the Bendix Aviation Corporation reports that in spite of their high proportion of handicapped people they had only one lost time accident. The injury involved was slight and the worker was not one of the handicapped people.

In a pre-examination of physical standards with a view to adapting them for handicapped persons, the following principles should be followed:

I. Outline a list of handicaps suitable for immediate placement in the particular employment.

II. List handicaps calling for temporary rejection until treated satisfactorily.

III. List handicaps which are unfit for any employment.

Under III may be a list of active tuberculosis, syphillis of the central nervous system, frequent epileptic attacks, severe diabetes mellitus, decompensated cardiovascular disease, psychoses, cancer, painful arthritis and any serious progressive disease.

Rehabilitation agencies, both state and national, should be called upon fully and use should be made of the job analysis of the United States Employment Service in order that the physical demand requirements of the job may be taken into account to safely place the worker with a handicap.

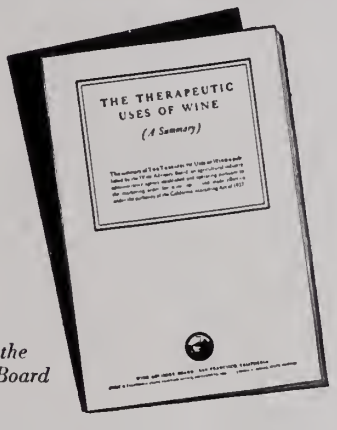
If the plant physician knows the physical requirements of each job and the hazards therein, he will then be able to sift out handicapped workers so that the final decision for placing them can be arrived at in consultation with the safey engineer, the personnel director and the physician. It is truly said that every person is capable of doing some useful work unless he is ill in the common meaning of the term. Physicians in Industry can aid the program of rehabilitation of returning soldiers, as well as chronically handicapped civilians, if they will re-examine the hazards of the particular jobs in the plant and examine the pre-replacement physical requirements with a broad view to gaining a useful worker for industry in these critical times.

JANUARY MEETING

The regular meeting of the Industrial Physicians Society was held on January 18th at the Rhode Island Medical Library. The topic of the evening was a round table discussion of Industrial Medical and Nursing practice.

FACTS DOCTORS SHOULD HAVE ON

WINE
IN THE DIET



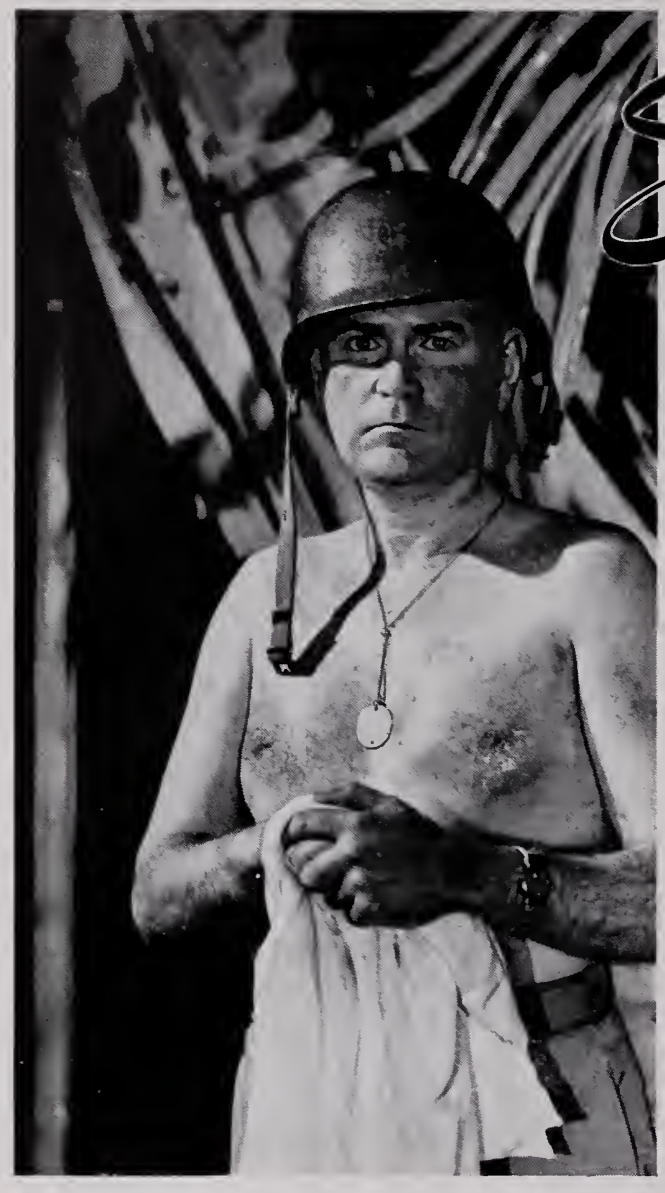
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DISCUSSIONS of wine's historical uses . . . the caloric content of wine . . . its dextrose and levulose content . . . its vitamin and mineral constituents . . . the assimilability of the ferrous iron in wine . . . etc. . . . form one of the chapters of *The Therapeutic Uses of Wine (a Summary)*. This review in monograph form has been prepared by competent medical authorities. It should be of interest to specialists in many fields as well as to the general practitioner.

THE CONTENTS INCLUDE: Sections on the actions of wine on the gastro-intestinal system, the cardio-vascular system, the kidneys and urinary passages, the nervous system and the muscles, and the respiratory system. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and the convalescent. The value of wine as a vehicle for medication. The contraindications to the use of wine. And an extensive bibliography for those who may wish to pursue the subject further.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

A copy of *The Therapeutic Uses of Wine* is available on request to any member of the medical profession. Write for it, to the Wine Advisory Board, 85 Second Street, San Francisco 5, California.



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RIDING A FLYING AMBULANCE

On Thanksgiving Day I flew about fifteen hundred miles, round-trip, and when I returned, I had some cold turkey, peas, potatoes and the inevitable Navy beans.

By the way, I've had some hops in the same plane and with the same crew with whom I flew here some time ago. They are a great bunch and they call me a member of the crew now. The ship has been refitted as a flying ambulance and what a job she can do! Maybe you can imagine what a feeling it gives me to fly with her and care for a load of casualties. She weights about thirty-five tons fully loaded—a deep bellied giant in her war paint, with a big white star and bar on her nose and wings. It's a great sight to climb up the ladder into the navigator's observation turret and look at the bright stars overhead as she goes on thru the Pacific night. You can look out over the big wing and the four engines, with their constant deep roar, each with two stubby stacks from which the hot blue-white exhaust flames send out banners three or four feet long. When we fly "dead-head" (empty one way) I like to sit in the pilot's seat for an hour or so. Nothing to do—the automatic pilot flies her with occasional corrections as we get a new bearing from the navigator. Of course, when we are loaded, I spend most of my time below, where the white stretchers and bandages are all that are visible in the darkness.

We had a fine trip the other day. We were the first to fly in and evacuate casualties from a certain combat area while the fighting was still going on. We landed on the water and, wearing our tin hats, loaded forty-one patients aboard, keeping a wary eye on the goings on nearby. One couldn't suppress a comfortable feeling of warmth and a wry grin as he looked up occasionally to where the low hum of swarms of fighter planes could be heard protecting us. "God bless the fighters" is never breathed so fervently as when you are sitting on the water loading wounded aboard! Then the take-off. The plane is very hot because it is made of metal and the water-tight compartments are closed (for the take-off only). I am in the compartment with those most critically hurt. A sudden deep roar as the throttles open, the plane lurches ahead, bumping over the waves, ever more rapidly until a sudden lurch upward and the ride becomes very smooth. You know you are off the water. The engines roar on under full power for a few minutes until we gain altitude then they are throttled down to cruising speed. I have a corpsman with me. We check each man—the nature of his injury and a quick examination reveals the attention he needs.

Back and forth on the catwalk with my flashlight —one man wants water, another is white with pain or from loss of blood, and others want a cigarette. Now and then one needs plasma or morphine or maybe someone to help him smoke if he can't hold a cigarette himself. But with all the injured it's the same—you never hear a whimper or complaint. To them I'm just plain "Doc" and they know why I'm there.

You can't describe these fighting men—and those whose fighting days are over. They are wonderful! They don't talk much—there is too much noise and, too, there's nothing to talk about. You don't try to be smart or flippant with them—nothing is very damned funny to them now. They don't complain. An hour or so ago, they belonged to the guns and tanks and planes—but now they are mine—they belong to the Medical Corps which exists only for them. They have done their job and have paid for their share in America—they and their buddies who aren't coming back in this big gray hospital plane.

After everyone is cared for we can stop for a drink of water and a smoke. I look out the port and see a couple of fighters high overhead. One peels off and dives, pulling out at our level and cruises some distance alongside. The pilot raises his hands clasped like a handshake—wiggles his wings as a salute, then banks away to return to the battle. We don't need him any longer.

When we get back "home"—late that night—there are many hands to help us. Several boats meet

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DISTRICT SOCIETY MEETINGS

THE WASHINGTON COUNTY MEDICAL SOCIETY

The Annual Meeting of the Washington County Medical Society was held January 12, 1944, at the Elm Tree Inn, Westerly, Rhode Island.

Dr. Anthony V. Migliaccio was the speaker of the day and he gave an informal but very interesting lecture on some unusual cases he had attended. The first series was on Meckel's Diverticulum, illustrated with lantern slides. The next series was on the surgery of the Common Duct, with X-ray films. The final part of his lecture was a moving picture in color showing the technique of extra peritoneal caecostomy. Discussion followed.

The business meeting was conducted by the President, Dr. H. P. Gongaware.

Drs. Grenolds, Jones and Ruisi were appointed a nominating committee.

The Treasurer's Report was read, accepted, and placed on file.

A letter from Mr. Farrell was read asking endorsement of the "Keep Well Crusade" launched by the State. This was approved, and it was suggested that the matter be presented to the Westerly Medical Society at its next meeting.

The nominating committee brought in the following slate which was voted in:

President
FERNALD C. FITTS, M.D., Westerly, R. I.
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FRANCES A. KENYON, M.D., Woodville, R. I.
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SAMUEL C. WEBSTER, M.D., Westerly, R. I.
Delegate for 2 years
JULIANNA R. TATUM, M.D., Westerly, R. I.
Councillor for 2 years
JOHN P. JONES, M.D., Wakefield, R. I.

The new President then took the chair. The meeting adjourned and dinner was served.

JULIANNA R. TATUM, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

A meeting of the Pawtucket Medical Association was held at the Memorial Hospital on Thursday, January 20.

President Joseph Doll announced the appointment of Dr. John F. Kenney to serve the unexpired term of Dr. Wheaton as councillor from the Pawtucket Medical Association to the Rhode Island Medical Society. By reason of his office as vice president of the State Medical Society Dr. Wheaton is a member of the Council.

Dr. Stanley Sprague reported on the radio program of the Association and he anounced that he wished to have a decision as to whether or not the program should be continued. It was voted

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FERNALD CHURCHILL FITTS, M.D.
of Westerly, R. I.
President of the Washington County Medical Society for 1944

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DISTRICT SOCIETY MEETINGS

continued from page 84

that every effort be made to continue the weekly talks.

Dr. John F. Kenney reported on the meeting of the Council of the Rhode Island Medical Society held the previous evening, and he discussed briefly some of the more important matters and the action taken on them.

Dr. Doll called attention to the display published in the Providence Journal by the Providence Medical Association as a tribute to its members in military service and he asked for a vote as to whether a similar display for the Pawtucket Medical Association might be carried in the Pawtucket Times. It was voted that the Association carry through such a program.

The guest speaker for the meeting was Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society, who gave a resumé of the existing and proposed health programs in the State in which he interpreted the part that the medical profession was playing and would have to play in the coming months. He discussed the Rhode Island Cash Sickness Compensation Act in detail, and in the question and answer period following his talk he replied to the many inquiries advanced by the members of the Association.

Respectfuly submitted,
WILLIAM N. KALCOUNOS, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

The scientific program of the 97th Annual Meeting of the Providence Medical Association, held at the Medical Library on Monday, January 3, 1944, consisted of papers by Dr. George W. Waterman on "Carcinoma of the Endometrium," Dr. Edward J. West on the "Recent Epidemic of Poliomyelitis", and Dr. William A. Horan on the "Kenny Treatment of Poliomyelitis."

Dr. Waterman's excellent paper presented a thorough statistical analysis of 140 cases treated at the Rhode Island Hospital and in some instances elsewhere, during the past eighteen or twenty years. Carcinoma of the endometrium is about one-fifth as common as carcinoma of the cervix. It occurs typically at a later stage in life, most of the patients being past fifty years of age. The cases were divided into four stages from the very early ones involving only the endometrium to those with extensive extension to other structures.

Of the 140 cases, 80 were followed for a period of five years. 36% of these patients survived the five-year period. 63% of those in the first stage

continued on page 91

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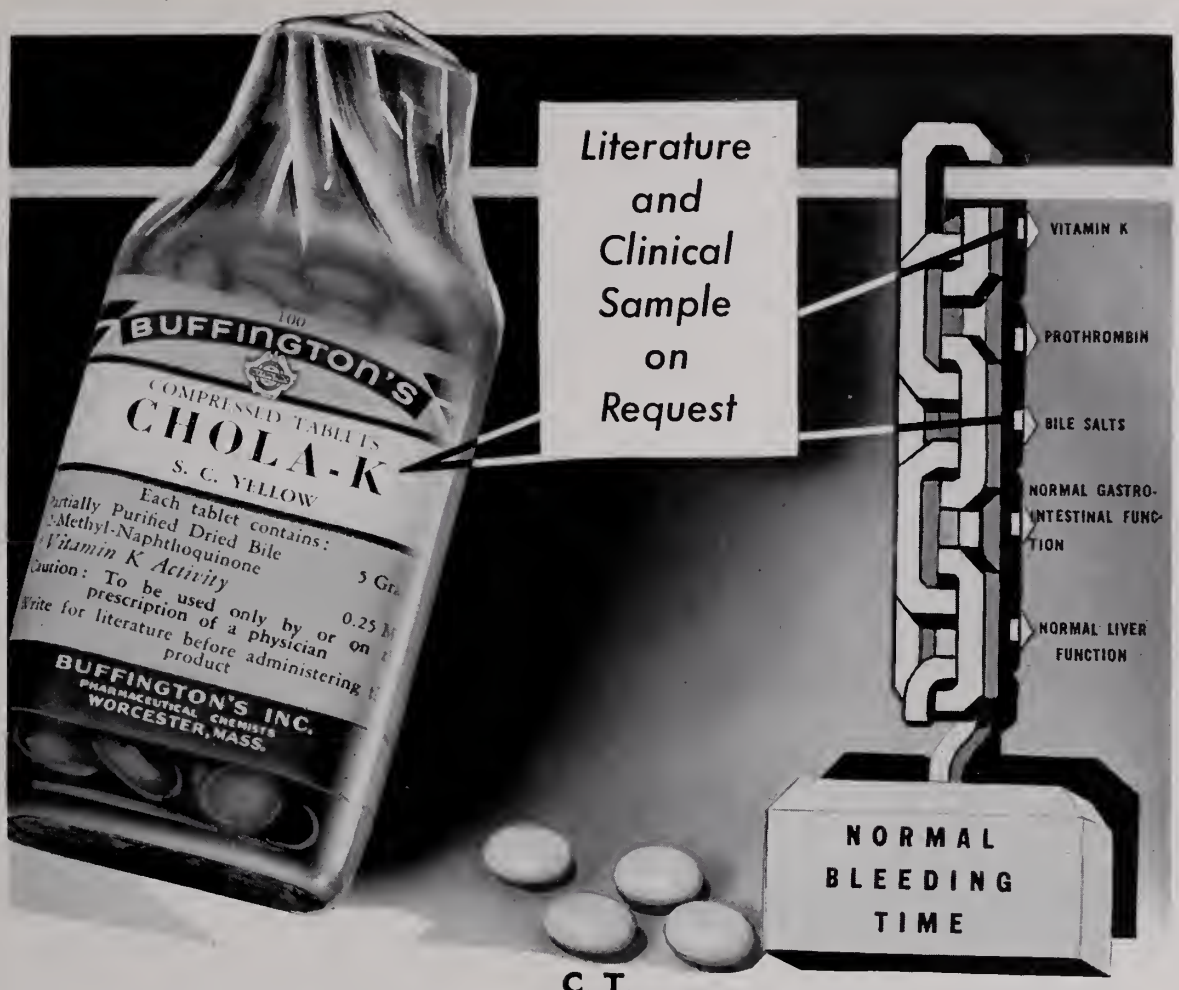
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References

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DISTRICT SOCIETY MEETINGS

continued from page 87

survived the five-year period. Not one of the twelve patients classified as fourth stage has survived this length of time. Dr. Waterman reported the pathological examination of 48 hysterectomy specimens in this condition. Even the most careful radiation does not satisfactorily sterilize the uterus of cancer cells in a satisfactory number of cases. The point is made therefore, that radiation alone should not be depended on in treating carcinoma of the endometrium; in fact, surgery is stressed as the primary method of treatment.

Dr. Waterman's paper was discussed by Dr. Pitts who complimented the essayist upon the great amount of work necessary to compile the statistics from which such valuable conclusions as to the proper treatment can be drawn.

After the election of the slate of officers headed by Dr. Albert H. Jackvony as President, to serve for 1944, the Association adopted recommendations made by the Executive Committee to provide for appropriations for the use of the Library, for the purchase of Medical journals, and for a proportionate cost of the operation of the executive office in conjunction with the State Medical Society.

The Association also adopted a recommendation that the assessment of dues for 1944 be established at $15.00 for active members and $5.00 for associate members.

Upon the recommendation of the Executive Committee the Association elected to active membership Ada Bedinger, M.D. of Butler Hospital, and Bernard B. Selzer, M.D. now serving with the armed forces.

Dr. Henry E. Utter called attention of the membership to the fact that the American flag placed in the auditorium was a gift of the retiring President, Dr. Emery M. Porter and was the property of the Association. A motion was made that a vote of thanks be extended to Dr. Porter for his generous gift and that a marker suitably inscribed be attached to the flag pole.

RIDING A FLYING AMBULANCE

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the plane with men to help unload. We are met on the ramp by the "big shots" and plenty of ambulances. A few words of commendation, some questions about how things are going and then, after the patients have left in the ambulances, we carry our kits and helmets home, grab a snack and go to bed.

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This is my job—to do what I can (and sometimes it seems like *so* little) for these men. I can't describe them — their tired, dirty faces, scraggly beards, blood-stained bandages and the white faces looking to me for help. They and thousands who are still fighting are nothing short of magnificent. I'm proud of my job and you and the people who have helped so much to give me the training I needed to do it.

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REPORT OF THE MILK COMMISSION OF THE PROVIDENCE MEDICAL ASSOCIATION

1943

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All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

A yearly inspection of our local farms producing certified milk was made by Dr. Tompkins, representing the National Association, and his reports have been very favorable. His suggestions have been helpful and instructive.

Since the Providence Medical News has been discontinued, we are advertising Certified Milk in the Rhode Island Medical Journal.

The Commission is indebted to Dr. Knights, Deputy Inspector of Milk in Providence, for his continued interest and co-operation during the past year.

The personnel of the Commission includes Drs. Harold G. Calder, chairman, Henry E. Utter, George W. Waterman, Frank I. Matteo, Maurice Adelman, William P. Shields, Thomas J. Dolan, Raymond L. Webster D.M.D. of the Rhode Island Dental Society, and Reuben C. Bates, Secretary and Treasurer.

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January	4.2	12.90	2,412		4.2	13.34	2,468	43	4.1	12.89	135	3.9	12.70	1,983		
February	4.1	12.87	3,075		4.5	13.55	2,866	23	4.0	12.93	66	3.8	12.56	2,650	15	
March	4.	12.73	1,966	12	4.2	13.30	2,288	64	3.9	12.75	56	4.0	12.77	1,866		
April	4.2	13.03	2,776		4.3	13.47	2,194	15	4.0	12.93	24	3.8	12.59	9,390		
May	4.	12.73	2,800		4.2	13.39	1,831	7	4.1	12.93	14	3.8	12.64	15,425		
June	4.	12.63	4,025	50	4.2	13.27	2,278	21	4.0	12.94	13	4.0	12.80	6,816		13
July	4.1	12.88	2,175		4.4	13.47	3,238	155	4.0	12.69		4.1	13.			26
August	4.1	12.72	4,100	16	4.7	13.76	4,787	51	3.9	12.63		4.2	13.15	5,500		
September	4.	12.83		53	4.2	13.27	2,075	318	4.2	12.85	19	4.0	12.72		12	26
October	4.4	12.71		64	4.3	13.62	3,031	32	4.3	13.29	15	4.1	12.94		26	44
November	4.	12.76		24	4.2	13.46	1,770	30	4.1	12.97	25	3.9	12.74		38	35
December	4.1	12.96		24	4.3	13.54	4,287		4.1	13.20	52	3.8	12.61		50	65
Yearly Average	4.1	12.81	2,916	35	4.1	13.45	2,759	69	4.1	12.91	42	3.9	12.76	6,232	28	35

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**Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245. ***Laryngoscope, 1935, XLV, No. 2, 149-154.*

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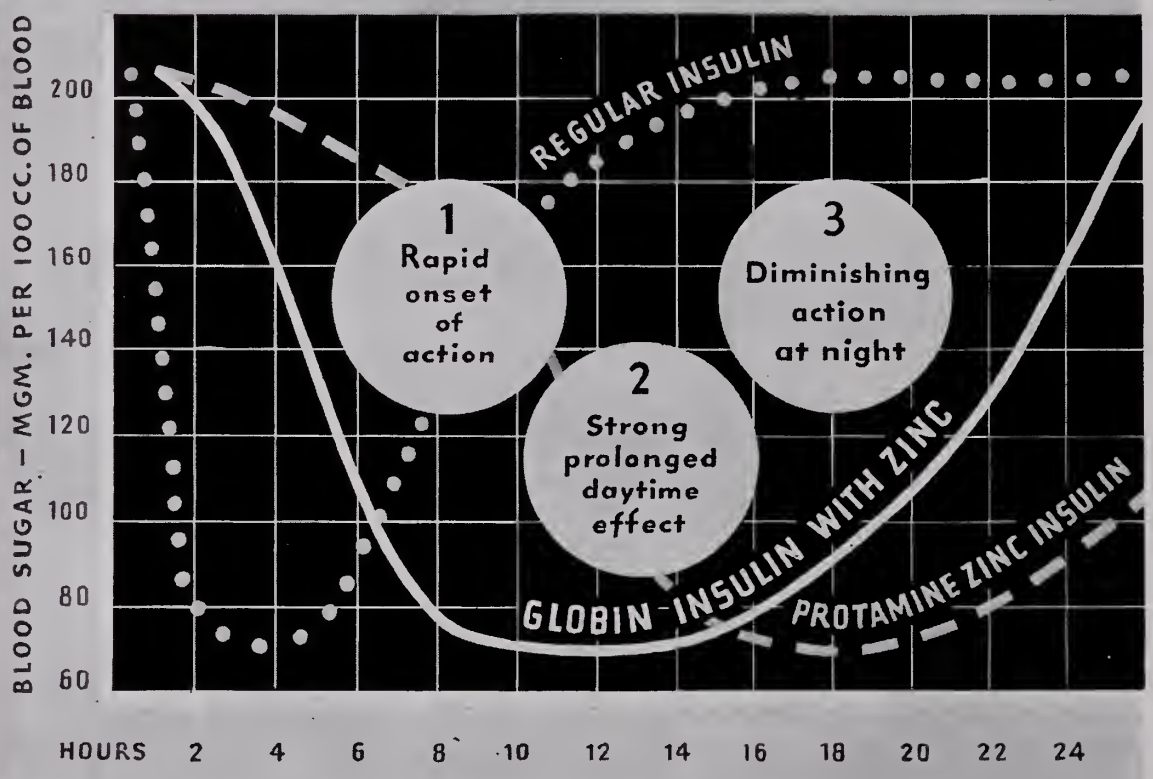
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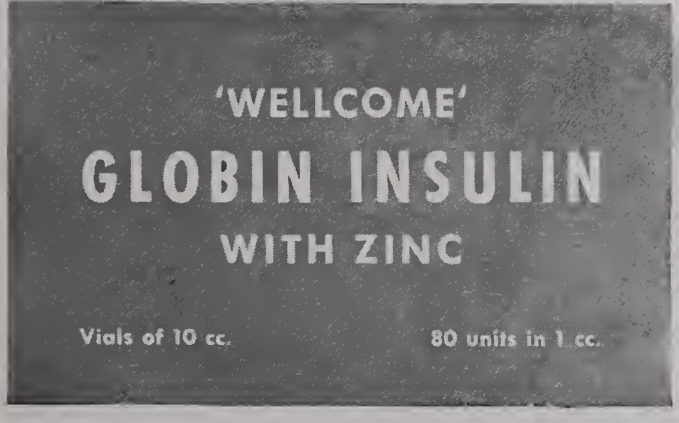
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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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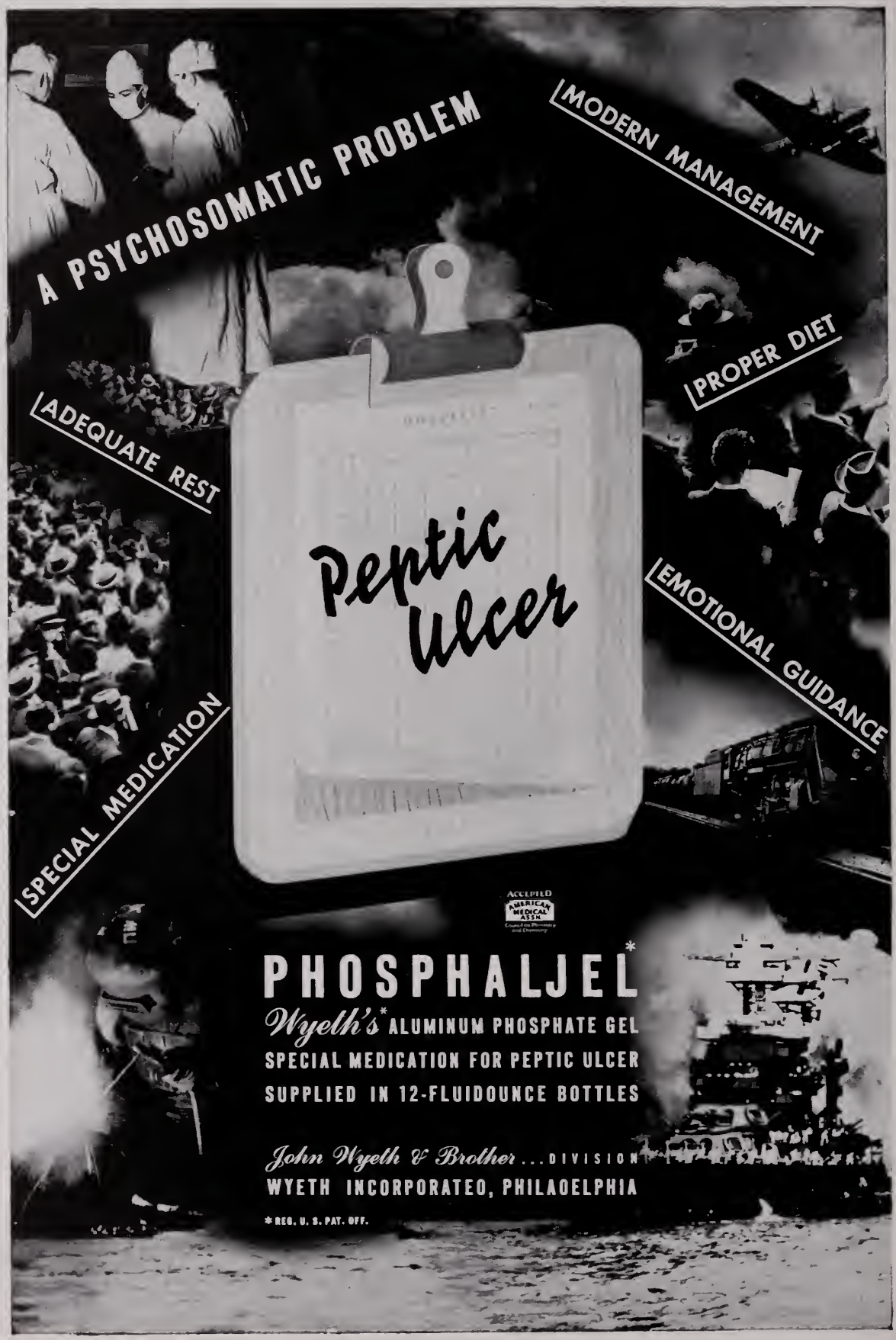
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At Providence . . . MAY 24 and 25

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ut so far I have learned of no other e suggestion which provides the neces- fety valve which such an arrangement would give. It would be tragic if a lot li business concerns were wrecked and orkers thrown into idleness because of nability to cut through the red tape ed in getting their claims settled.

RESPONSIBILITIES OF CONTRACTORS

le making these statements with re- o action by the Federal authorities, I ize, also, that business concerns which war contracts have a responsibility on part to facilitate speedy settlement of ated war contracts. They have the re- ility for preparing their claims ac- y and speedily and presenting them per form. Some progress has been toward getting a recognition of the at industry must play in this respect, rrently more and more experience of ort is now being gained. The con- g services of the Government, I know, very helpful attitude toward this sit- , and the local office of W. P. B. has shed a regional advisory service for war faced with problems resulting from termination. That is a very helpful nent.

ation to make possible the prompt nt of terminated war contracts is now. It will be unsafe to wait until s a deluge of contract terminations to hrough legislation on short notice. roblem is too complicated to be dealt fectively in that way.

ATERIALS FOR CIVILIAN PRODUCTION

ddition to making provision for the ent of terminated war contracts, there the task of facilitating the flow of als for civilian production as soon as materials can be spared from war pur- I hope that we shall not have unem- ent here in Massachusetts because d materials, which are physically in ex- e in the United States, are unavailable by manufacturers as a result of leg- or administrative restrictions. The legislation vesting the priority power President, which power of the Presi- delegated to the Chairman of the War on Board, is probably adequate to the flow of materials, but it may ba ry for the Congress to make sure that ministration of the priority power by ar Production Board is directed effec- toward the speedy and smooth resump- f civilian production. The War Pro- n Board should be expected to elim- s limitation orders, its conservation and its allocation systems just as s the needs of the war program per-

use of their effects on plans for re- yment, I foresee that these problems tling canceled contracts and securing pplies of raw materials for civilian pro- n will presently be matters of wide- concern here in Massachusetts.

ummarize, my specific recommenda- re that legislation should be enacted r the following points:

EMENT OF TERMINATED WAR CONTRACTS

terminated contracts should be set- egotiation by the contracting agen- the Government, and the negotiated nt should be final in the absence or misrepresentation.

mpt partial payments amounting to large percentage of the claim should d to each contractor upon submittal ified statement of the claim, subject, , to a penalty for perjury.

al settlement committees should be red to authorize partial payments delay of over 30 days occurs on the the Government agency.

4. Contracting agencies should be required to give prompt clearance of claims on work in process. There should be clear-cut procedures for authorizing tha removal of Government-owned inventories and machines, with storage at Govarnment expense, in order that civilian production may be started.

5. The dilemma of the subcontractors must be resolved. At the present time the Government exercises the right of approving all payments in settlement of subcontracts but does not assume any responsibility to the subcontractor, with the result that the subcontractor in many cases cannot secure action by either the prime contractor or the contracting agency. I suggest that the local settlement committees proposed above should be empowered to approve settlement of subcontracts if a delay occurs in approval by the contracting agency.

B. DECONTROL OF MATERIALS

1. As soon as war conditions permit, the rules for the release of scarce raw materials should be revised, with a view to facilitating the rapid resumption of civilian production.

A Magnificent Job

EXTENSION OF REMARKS
OF
HON. LOUIS LUDLOW
OF INDIANA
IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 11, 1944

Mr. LUDLOW. Mr. Speaker, Indianapolis and Indiana are very proud of the great pharmaceutical house of Eli Lilly & Co., which has processed its millionth blood donation without a cent of profit. This record is in keeping with the fine, generous spirit which this firm always has manifested in the service of our country and which long ago brought to it the recognition of an Army-Navy E award. Commenting on the company's contribution to the blood campaign, which means so much in saving the lives of our precious boys, the Indianapolis News says editorially:

LILLY'S CONTRIBUTION

In the midst of charges that some concerns are making an unholy profit from war contracts it is heartening to learn that the Indianapolis laboratories of Eli Lilly & Co. have processed 1,000,000 blood donations entirely on a nonprofit basis.

In addition to performing this service at cost, the expense involved has been decreased constantly through the introduction of more efficient methods.

There certainly could have been nothing unethical if the Indianapolis pharmaceutical house had sought a minimum profit for the work it has been doing.

Donations of blood at Atlanta, Chicago, St. Louis, Detroit, Cincinnati, Louisville, Columbus and Indianapolis hava been converted into live-saving plasma at the Lilly plant, involving the installation of new equipment and the employment of much additional skilled personnel.

The patriotic Americans who donated this blood, however, got nothing for their contributions and the Lilly Co. determined that its connection wiht tha effort to strengthen the wounded on every fighting front should ba entirely shorn of private gain. From beginning to end, it has been and is—a magnificent job.

The Gates Must Not Be Closed

EXTENSION OF REMARKS
OF
HON. SAMUEL DICKSTEIN
OF NEW YORK
IN THE HOUSE OF REPRESENTAT

Tuesday, January 11, 1944

Mr. DICKSTEIN. Mr. Speaker, leave to extend my remarks in the ORD, I include the following editoria the Daily Mirror of January 4, 194

THE GATES MUST NOT BE CLOSE

When Congress reconvenes on Janu it should take up the Gillette-Taft-Bal Rogers resolution.

This resolution calls for the format a Presidential commission to create m ery, in conjunction with tha Unite tions, to rescue the millions of Jew are now being systematically exterm by the Nazis and their Quislings.

When the Presidential commission g work, one of tha first things it should to seek the abrogation of the Cham "White Paper" of May 1939.

At present, Palestine is being admi by Great Britain in conformity with t icy embodied in the "White Paper," tue of which Jewish immigration int tine is now limited and is to be pr stopped after March 31, 1944. The to be reduced to a permanent min 33 percent in the country and the land to Jews is to be practically pro

A DIRECT REPUDIATION

This is a direct repudiation on En part of the League of Nations Manda the Balfour Declaration incorporated mandate of 1917.

According to this declaration, Palest to become a national Jewish home un protectorate of England.

In 1920, after the Jews had created ern civilization in what was practic Arabian desert, England turned h on her solemn promise of 1917.

This perfidity of Britain toward t was denounced by no one more vig than by Winston Churchill in Parlian the debate on the "White Paper" when he said:

MR. CHURCHILL'S REGRET

"As one intimately and responsib cerned in the earlier stages of our P policy, I could not stand by and see engagements into which Britain has before the world set aside for reason ministrative convenience or for the quiet life. I should feel personally rassed in the most acute manner i myself by silence or inaction to wha regard as an act of repudiation.

"I regret very much that the pledg Balfour Declaration, endorsed as it h by successive governments, and the tions under which we obtained the m have both been violated by the Gover proposal.

"I select one point upon which plainly a breach and repudiation of four Declaration—the provision tha immigration can be stopped in 5 ye by the decision of an Arab majority. a plain breach of a solemn obligation

As the Palestine Mandate was ord the League of Nations, it cannot b gated even by Great Britain herself the consent of the League.

A SOLEMN OBLIGATION

But tha League did not give its cons the 1939 abrogation.

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVII MARCH, 1944 NO. 3

ACUTE RESPIRATORY DISEASES*

ALEX M. BURGESS, M.D.

Author: *Alex M. Burgess, M.D., Visiting Physician, Rhode Island Hospital, Providence.*

WITH the knowledge that influenza and the common cold are caused by viruses, organisms quite different from the ordinary pathogenic bacteria which we have long known to be associated with acute and chronic disease of the respiratory tract, it is of great interest to clinicians to study and compare these two great classes of disease, especially from the point of view of therapeutics. We are also particularly concerned with the interdependence of virus and bacterial infection.

In the great pandemics, as in 1918, when it appears that the virus of influenza reaches a very high degree of virulence, instances are by no means rare in which such infections are overwhelming and death occurs probably as the result of the original infection alone. In the lesser epidemics, however, almost all the deaths from influenza probably result from secondary bacterial infection. Even in many fulminating cases like those so often seen in 1918, bacterial invasion may be the deciding factor as, for example, those cases of staphylococcus aureus infection reported by Dr. Gormly and me in the epidemic of 1929.

In these epidemics the usual sequence when pulmonary involvement occurs is a frank bacterial infection following the initial attack of influenza. Studies of the 1926 and 1929 epidemics here in Providence showed a great increase in the incidence of lobar pneumonia during these epidemics, and to this rule the present outbreak has been no exception.

In my own experience certain years stand out as marked in my memory. These are—after 1918—the following, 1920, 1926 and 1929. Doubtless to many of you other years will seem equally important as small epidemics have occurred almost every year between 1930 and 1940.

*Presented at joint meeting of the Rhode Island Medical Society and the Providence Medical Association, at Providence, February 7, 1944.

Recent Epidemics

We are, however, principally concerned with the very recent past. To take the winter season of 1942-43 first, my conception of what occurred is about as follows: This is based, especially, on an easily observed group of young people, students at Brown University and Pembroke College, with whom during that season I was intimately concerned. During the summer and fall of 1942 up to the Christmas holidays, the prevailing infection was a mild tracheo-bronchitis with a fairly large number of cases of demonstrable pneumonitis corresponding to that condition known to the army as "a typical broncho-pneumonia, etiology unknown" which we are accustomed in this community to call "virus pneumonia." These patients showed the usual X-ray picture and the low or normal leucocyte count. Following the opening of college in January, however, the situation changed abruptly. From this time on rather severe cases of pharyngitis occurred, characterized by a rather high fever and an intensely sore throat. These patients also showed a low leucocyte count and were recorded as cases of influenza but none of them developed pneumonitis. The throat was intensely red with hyperplastic lymphoid tissue standing out in bold relief, but no ulceration or exudate. It was interesting to me that in talking with Dr. Francis Blake of New Haven I learned that he had noted a similar change in the type of disease and felt that a different virus must be the cause of the January outbreak.

In the beginning of December 1943 another outbreak occurred in this community, apparently a part of a country wide if not world wide epidemic. This has not, I believe, subsided as yet and most of us who are doing medical and general practice are still seeing a good many cases. As usual, a great increase in the number of cases of lobar pneumonia followed. The accompanying tables show this sequence very definitely.

continued on next page

Table I

	INFLUENZA				PNEUMONIA			
	P*	B*	R*	T*	P	B	R	T
Dec. 1- 7	5	40	4	*49*	0	1	9	*10*
Dec. 8-14	10	34	10	*54*	2	2	18	*22*
Dec. 15-21	14	32	12	*58*	6	1	19	*26*
Dec. 22-28	8	2	11	*21*	6	1	22	*29*
Dec. 29-Jan. 4	10	12	7	*29*	5	3	15	*23*
Jan. 5-11	2	3	1	*6*	2	0	15	*17*
Jan. 12-18	3	11	3	*17*	0	0	12	*12*

*P Private patients
B Brown University
R Rhode Island Hospital
T Total

Each of us can write his own description of the typical case of influenza of the present outbreak and I do not think that there would be much discrepancy. Of those that I have seen about half occurred following a few days of what was thought to be a common "cold" and in about half the onset was abrupt, with or without an actual chill. Headache, general aches and malaise were present to a varying degree but, in contrast to the students observed a year ago, sore throat was usually absent and cough was severe and persistent. In addition there were a small number of patients whose illness began with nausea and vomiting as well as fever, and in whom cough was absent. This group seemed so distinct from the others as to make one wonder if it were not the result of a different virus. In one patient, a doctor, an attack of this latter type with a rise in temperature to 103° occurred during convalescence from an attack characterized by cough, fever and a few pulmonary rales, and it seemed as if he had been sufficiently unlucky to encounter both types of infection. All these ideas as to different viruses are, of course, purely conjecture but it is to be hoped that in places where the difficult task of isolating and identifying the virus of influenza is carried on such studies will yield interesting and valuable data concerning the types of infection that have been prevalent this winter.

As regards pneumonia in the current outbreak, one can say that frank lobar pneumonia has been frequent but broncho-pneumonia more frequent. I am indebted to Dr. Lawrence Ross, recently medical resident at the Rhode Island Hospital, for the figures shown in Table II. Many of the patients with broncho-pneumonia were not given the sulfonamides. On the whole those who received the drug did slightly better than those who did not. Among patients with lobar as well as broncho-pneumonia there was a surprisingly large number who failed to react well to sulfonamide therapy—11 out of 30 in lobar pneumonia and 11 out of 40 in broncho-pneumonia.

Principles of Treatment

As regards treatment of acute respiratory disease I believe that two main principles may be stated and that they can be applied in all but the very exceptional case. These are:

1. Virus infections are not benefited by sulfonamides.
2. Bacterial infections are usually benefited by sulfonamides. This is particularly true of most pneumoccal infections, and of many others.

I believe these two statements are generally admitted and are supported by an overwhelming amount of both experimental and clinical evidence.

In treatment therefore, if the infection appears to conform clinically to the typical picture of influenza or "virus pneumonitis", I believe that sulfonamides should be withheld on the ground that they are useless and capable of producing harmful results. In lobar pneumonia or other infections apparently due to bacteria I believe that they should usually be used, and used vigorously and with in-

Table II

1926 March—41
1929 January—68
1943 December—73

Lobar 21
Broncho 52
73

Comparison of the incidence of pneumonia at the R. I. Hospital in the epidemics of 1926, 1929 and 1943-44.

Blood cultures—Pneumococcus Types 1, 2, 3, 4, 6, 7, 8
Staphylococcus Aureus

Mortality for December and January—119 cases

1. Lobar pneumonia 38 cases 6 deaths 19 per cent
One patient moribund corrected mortality 16 per cent

2. Broncho-pneumonia 81 cases 14 deaths 23 per cent
Six patients moribund corrected mortality 8 deaths 13 per cent

sistence on a high fluid intake and adequate alkalinization for the patient's protection. In the severer cases the use of the sodium salts of sulfadiazine or sulfamerezine with the resulting immediate high concentration of the drug in the blood, is, I believe, at times a life saving measure.

When it comes to the doubtful cases, of which there are many, I know of no reliable rule which can be applied. Every patient must be treated on the merits of his immediate condition with a number of facts taken into consideration. The leucocyte count is not by any means always a reliable guide

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SULFONAMIDES IN THE TREATMENT OF THE COMMON DISEASES OF THE UPPER RESPIRATORY TRACT*

KALEI K. GREGORY, M.D.

The Author: *Kalei K. Gregory, M.D., Assistant Superintendent, Charles V. Chapin Hospital, Providence.*

THE sulfonamides have been in general use for approximately seven years. Their efficacy in the treatment of certain infectious diseases has been established. The modern physician possesses a most valuable therapeutic agent, and yet with it all, there are limitations in its use. The ideal drug is not yet found that can be used effectively against all infectious diseases and at the same time be free of all harmful effects. Until that is found, it is incumbent upon the physician to be thoroughly familiar with the advantages and disadvantages of the present group of sulfonamides in order that he may use them wisely and effectively. I should like to discuss first, their indications and limitations, and second, their application to diseases of the upper respiratory tract.

Briefly, the sulfonamides are indicated in certain bacterial diseases or infections, particularly in those caused by the beta-hemolytic streptococcus, pneumococcus, meningococus, and gonococcus. Clinical experience everywhere has shown, beyond a shadow of doubt, the efficacy of these drugs in diseases caused by these organisms. Less certain and less universally supported, are the effects of the drugs on staphylococcus, bacillus coli, influenzal bacillus, Friedlander's bacillus, bacillary dysentery, and undulant fever. It must be remembered that each individual drug is more successful in certain diseases than in others. For instance, sulfanilamide is very effective in beta-hemolytic streptococcic and meningococcic infections, more so than in those caused by the pneumococcus. Likewise, sulfathiazole is more efficient in pneumococcic pneumonia and gonococcic infections than in beta-hemolytic streptococcic or meningococcic infections.

Sulfadiazine, on the other hand, has been shown to be equally successful in beta-hemolytic streptococcic, pneumococcic, meningococcic, gonococcic, and possibly influenzal bacillus diseases. Great things have been promised of sulfamerazine but it has not been in use long enough to be fully evaluated.

The sulfonamides, in general, have been found to be ineffective against virus diseases except for perhaps lymphocytic choriomeningitis, lymphogranuloma venereum, and trachoma.

Reactions and Complications

The ideal drug must not only be effective in all or in most infectious diseases, but also must be free of harmful effects. Individually and as a group, the sulfonamides produce a number of reactions and complications, some of which are minor and inconsequential, others severe and serious, but all are more or less preventable if care is taken in handling the drugs. Time does not permit me to discuss fully all the details of the various reactions so I shall confine myself, first, to what might be considered a sensitivity reaction and, second, to what might properly be called complications of the drugs.

As a group, the sulfonamides show, in the order of frequency, the following reactions; skin rashes with or without fever, and fever alone. These reactions make the patient hypersensitive to the particular drug used and, as a rule, also to the entire group. Subsequent use of the drugs is risky and inadvisable. It is this type of reaction which causes one to carefully consider the indications before deciding to give the drugs.

Damage to the kidneys and ureters may be properly considered a complication. This is caused by the crystals which may block the kidney tubules, pelvis, or the ureters. It is preventable if certain precautions are taken, such as a liberal fluid intake or the addition of alkali to produce alkaline urine, thus enhancing the solubility of the crystals. It may be added that it is a wise procedure to inquire into the urinary history of the patient before giving the drugs. Disturbance of the blood-forming apparatus must be carefully watched, and the drug discontinued at the first sign of injury. Damage to the liver may also be a serious complication.

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Frequency of Reactions

The question may be properly asked, when and how frequent are these reactions? Various reports and our own experience at the Charles V. Chapin Hospital have shown that rashes and fevers occur usually between the ninth and the fourteenth day of therapy. Occasionally they may develop very early or late in the treatment. That they occur frequently enough is shown by a series of 200 cases of scarlet fever treated with sulfanilamide, in which 15 per cent developed skin eruptions, with or without fever, and 7 per cent developed fever alone. In 322 cases of meningococcic infection treated with sulfadiazine at the Chapin Hospital, 5.1 per cent developed rashes and 1.5 per cent developed fever without rashes, 78.8 per cent with hematuria and 2.7 per cent gross hematuria. During the past three weeks, to mention only recent experiences, four patients were admitted to the hospital with oliguria, fever, nitrogenous retention, and crystaluria. Two of the patients had skin eruptions. They all recovered, but not without some anxiety in two of them. Peculiarly, and perhaps fortunately for us at the hospital, we have had no death which was due to agranulocytosis, but several have died from kidney damage.

Thus, the indications for the use of the sulfonamides are based primarily on the kind of bacteria involved, and the fact that the drugs are ineffective in virus diseases. The reactions and complications are handicaps which, on the whole, can be avoided by judicious use of the drugs. The most important reaction, and the one which should be avoided if possible, is sensitivity to the drugs.

Aids Against Secondary Bacterial Infection

The causes of the common diseases of the upper respiratory tract are the virus and bacteria. The common cold, the biggest nuisance of all, is caused by a virus. The sulfonamides have no influence over this disease. They likewise have no effect on the virus of influenza. However, as these diseases often pave the way for secondary bacterial infection, the drugs may be indicated and can be expected to be of inestimable value. The organisms which are common secondary invaders are, for the most part, those in which the sulfonamides are most effective, namely, beta-hemolytic streptococcus, pneumococcus, meningococcus, influenzal bacillus, and staphylococcus. In actual practice, when the physician sees the patient at home, he is not able to determine precisely the incriminating organism, but he can get a pretty good idea by analyzing carefully the presenting symptoms and signs. I do not mean to imply that this is absolutely necessary, but I think it is good medicine and certainly it is good for the soul. The important thing is the progress and extent of the lesion and the condition of the patient.

For instance, a patient with fiery red, swollen tonsils or pharynx, and enlarged cervical glands, and with a temperature course ranging between 102 and 104 degrees, has good reasons to receive the drugs. On the other hand, a patient with a similar infection of less extent, even if the temperature is 104 degrees, may recover just as promptly by the use of simple measures as with sulfonamide therapy. One must remember that patients with simple infections of the upper respiratory tract got well before the advent of the drugs and they still do recover without chemotherapy. Cases of influenza which have passed the initial stage of the disease and in which signs of secondary infection are manifested by cough, purulent expectoration, and fever, may be given the drugs without waiting for definite signs of pneumonia. Infections of the middle ear and accessory sinuses should be handled in a similar manner. If the conditions are severe and extensive, the drug may be given liberally.

Children with simple acute laryngitis do not require chemotherapy, even if the process has involved the trachea and bronchi. Contrary to some reports, I believe the infection is caused by the same virus which causes stuffy nose, rhinitis, slight fever and malaise, otherwise known as common cold. However, here again, if the physician believes that secondary infection has taken place and there are indications that it may progress, the drugs may be used profitably.

Chemotherapy as Prophylactic Measure

The most interesting and controversial question is the employment of chemotherapy as a prophylactic measure. This, indeed, would not be a problem were it not for the reactions and complications which may not only endanger the life of the patient but also may deprive him of the use of the drugs when he is in dire need of them at some future time. Even these objections would be little ground for withholding the sulfonamides if there was evidence that the procedure would eliminate the offending organisms. In a series of 400 cases of scarlet fever, we found at the Chapin Hospital that the number of beta-hemolytic streptococcic carriers at the end of four weeks of sulfanilamide therapy was the same in the 200 controlled as in the 200 treated cases. Comparable results were found with sulfadi-

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THE SULFONAMIDE TREATMENT OF RESPIRATORY DISEASES IN CHILDHOOD*

HENRY E. UTTER, M.D.

The Author. *Henry E. Utter, M.D., Member of Visiting Staff, Department of Pediatrics, Rhode Island Hospital, Providence.*

TREATMENT of respiratory disease in children has changed materially since the advent of the sulfonamides. Other drugs still have their place in the management of symptoms and must not be relegated to the background on the assumption that the sulfonamides by themselves constitute the whole treatment of any given respiratory disease. The sulfonamides do control the major number of the bacterial infecting agents, but the inflammation due to the pathological processes caused by bacteria still require the use of other remedies.

In the presence of increased bronchial secretion atropine forms a valuable adjunct to the treatment of respiratory disease. In croup, tracheobronchitis and other pathological states characterized by the presence of a thick tenacious secretion, ipecac, squills and the iodides still have their place in the treatment of respiratory disease. In pneumonitis, bronchial or lobar, the Burgess method of oxygen administration relieves respiratory distress, promotes sleep and eliminates much of the exhaustion so often seen in pneumonitis.

Indications for Use of Sulfonamides

What are the indications for the use of the sulfonamides in diseases of the respiratory tract? Such a statement might seem radical and possibly be provocative of much discussion and adverse criticism, but I believe that the sulfonamides are indicated in all respiratory disease of childhood. One might except the rhinitis so often encountered in the infant in the first few weeks of life; such infants for the most part do not present toxaemia with fever but rather a local process involving the nasal mucous membrane and local treatment usually suffices. This absence of general symptoms may mean that the infant has not been hitherto sensitized to bacteria. When I make such a general statement, I would like to qualify the same by adding that in such general usage of the sulfonamides, that in the individual case the chemicals should be administered in proportion to the degree of illness and toxaemia rather than in terms of blood concentration of the drugs. In serious illness the proper blood concentration is important. The early work with the sulfonamides demonstrated the dosage necessary and now repeated blood concentration tests are unnecessary.

By this procedure of using the sulfonamides particularly at the onset of any acute respiratory disease much time is saved, the physician is relieved of many unnecessary visits and complications are reduced to a minimum. There have been those who contend that before administering the sulfonamides we should first give the blood a chance to develop antibodies against the infecting agent, but what evidence have we that the streptococcus, pneuococcus or staphylococcus ever produce any lasting immunity, so why wait?

Use in Virus Diseases

Should the sulfonamides be used in virus diseases? *The common cold.* In the presence of general symptoms—yes. The virus of the common cold is usually accompanied by the streptococcus or pneumococcus, both readily activated by the virus. The cold itself will do little damage, but the complicating organism will. The same holds true in virus pneumonia. Dr. Russell Cecil and coworkers in a recent contribution on the use of sulfadiazine in the common cold demonstrated that at the end of four days of administration of this drug that the bacteria in the naso-pharynx had almost entirely disappeared. However, his final conclusion was "as a result of this study we are opposed to the routine use of sulfonamides in the treatment of the common cold, but would favor their use in a few selected cases as a protection against severe secondary infection".[1] Who of us is keen enough to decide in a group of children who have head colds which ones are headed for severe secondary infections? How shall we choose? Rich or poor? Strong or weak? Certainly if the poor and careless were chosen, there would be a larger

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number of empty beds in our children's hospitals, these same beds now filled with infants and children with pneumonia not treated with sulfonamides before their admission to the hospital.

Influenza and measles, virus diseases. Metaphorically speaking, of a hundred men entering a battle, we know that a certain number will lose their lives. We have, however, no means of knowing before the conflict which soldiers will meet such a fate; of the graduating class of any college we know that at the end of five years a certain number will have passed on, but we have no knowledge at the time of graduation which ones will die. To carry the metaphor further, during an epidemic of influenza or measles, we do not know at the onset how many or which children will have cervical adenitis, otitis, pneumonia or a kidney complication due to secondary invaders. An editorial in the *New England Medical Journal* of December 9, 1943,[2] offers the suggestion that cases of influenza should be treated with sulfonamides to lessen the number of complications. In the past few years we have had many cases of measles. During these years I have administered the sulfonamides to every case coming under my care and to date have had no complications. Needless to state, the course of measles has been in no way altered by these chemicals. On the other hand complications of measles have been encountered in which cases the drugs had not been given during the course of the disease.

Otitis media. Catarrhal otitis may develop in the course of any respiratory disease, but if the sulfonamides are being used, it is seldom that the inflammation continues to the point of a purulent otitis. Occasionally if the Eustachian tube and middle ear are involved at the beginning of the infection, an abscess requiring myringotomy may appear even though the sulfonamides are administered at the onset of the infection. During the recent epidemic of influenza many children did have a catarrhal otitis on the fourth or fifth day of the disease, but relatively few of these cases required operative relief, the symptoms seldom lasting more than one day. If a child is encountered with a draining ear, the sulfonamides should be administered, and it is noteworthy that of these cases when mastoiditis does develop, the surgeon, for the most part, finds few organisms in the pus at operation. Certainly since the advent of the sulfonamides in our medical armamentarium, we seldom meet lateral sinus thrombosis, meningitis or brain abscess or septicaemia as complications of the mastoid disease. This is indeed a relief to those of us who remember the devastating and prolonged infections which required weeks of treatment in the decade of 1920 to 1930 following the epidemic of influenza in 1918.

There are those who believe that the streptococcus is the primary invader in otitis media and that the pneumococcus so often found in the purulent discharge of otitis is a secondary invader to the streptococcus. If this be true, then surely the sulfonamides are indicated in all cases of acute otitis. Dr. Wesley C. Bower[3] states that after myringotomy the use of sulfonamides reduces the discharge by 50%. In a series of 793 cases of otitis media purulenta mastoid disease was reduced from 136 in 1933 to 60 in 1938, a year marked by a severe type of infection.

Whooping cough. The sulfonamides are not indicated in this disease, but inasmuch as most complications of this disease are caused by the pneumococcus or streptococcus when a fever appears in the course of pertussis, it is fair to assume that the temperature arises from a secondary respiratory disease, and the sulfonamides should be given. Usually we will find in the household which harbors the case of pertussis that the adult members or other children in the family have respiratory infections which have been transmitted to the child.

Poliomyelitis. The sulfonamides will have no effect when the diagnosis has been established. When an epidemic of poliomyelitis is in progress, it is interesting to note that there is invariably a great increase in the number of children ill with an upper respiratory tract infection characterized by fever of two or three days duration, headache and vomiting. It is also noteworthy that during such an epidemic many more children than adults are afflicted. On the contrary, during an epidemic of influenza one finds adults as well as the younger members of the household infected with the virus. Surely there can be no harm in administering the sulfonamides even though a certain small proportion of these children do have a complication in the nervous system which we then, and not until then, call poliomyelitis.

Tonsillitis. Here if we consider the crypts of the tonsil as closed cavities as we classify the infections of other closed cavities such as the accessory nasal sinuses, the middle ear or meninges, the sulfonamides are of great value but must be continued for a longer period of time. In all closed cavity disease the sulfonamides do not permeate the tissues so rapidly, in the case of the sinuses more particularly owing to their poor vascular supply.

When cervical adenitis complicates the picture, the drugs must be continued for a greater length of time, but we must not forget that the swollen glands after the acute inflammation has departed may persist to some extent. Such glands will disappear by the use of general measures. Seldom do we now encounter protracted gland infections lasting six to eight weeks as we did in the presulfonamide days.

In such local infections as those involving the adenoid, tonsil, and nasal sinuses we now have access to the use of solutions of the sodium salts of the sulfonamides which form a valuable adjunct when applied topically to the infected areas.

Dosage for Children

What dose should be used in childhood? In severe or moderately severe infections a simple rule to follow is that of one gram per year of age for the first three years and after that a grain per pound body weight. In mild infections this rule need not be adhered to. In children of 6 to 10 years two to three grams a day will usually suffice in mild infections.

There is probably no danger of drug reactions inside of the first nine days. After that if there have been no indications previously, a white blood count should be done to note the presence of leucopenia. This is a far cry from the daily blood counts advised in the earlier days of the sulfonamides. In the event of vomiting the drug should be stopped, but we must not be too prone to ascribe to the drug the symptoms of the disease. In the pre-sulfonamide days how often did we ever encounter a child with a respiratory infection without some vomiting? This is about the easiest thing which a child does. Crystals of sulfathiazole or sulfadiazine must be watched for in the urine and the appearance of blood in the urine particularly from sulfadiazine would necessitate the stopping of the drug. When this symptom disappears, the drug may again be resumed. Rashes are of little importance, and when the drug is indicated, it should be continued in spite of the rash. These rashes are not precursors in childhood of graver drug reactions yet to come.

Some observers have reported that when persons have been given repeated courses of the sulfonamides that they may develop "an acquired sensitivity" to the drug. Fink and Wilson[4] recently reported their observations on 177 children who had received more than one course of sulfathiazole or sulfadiazine. They state "our studies indicate that the use of the sulfonamides does not appear to predispose to the development of reactions on readministration of the drug".

That children tolerate the sulfa drugs better than do adults, there can be no doubt. Infants and young children can take relatively larger doses than older children. Similarly infants and young children tolerate preventive inoculation more readily than older children. A dose of alum precipitated diphteria toxoid given to an infant does not produce any reaction. On the contrary an older child or those in their teens may have considerable local reaction and some malaise and chilly sensations on the following day.

Preventive Outlook of Respiratory Infection

What of the future in the prevention of respiratory infection. Evidence at present is against the use of oral vaccines so commonly employed by the public. A recent issue of the Journal of the A. M. A.[5] under current comment states, "The scientific evidence against the value of oral cold vaccines is overwhelming; consequently individual physicians and firms who deal in pharmaceuticals and who lend themselves to wholesale unrestricted distribution of such preparations are perpetrating an unwarranted commercial assault on the public pocketbook". The use of "cold vaccines" is not universally satisfactory. Certain selected cases do seem to benefit, particularly the allergic child, who is as easily sensitized to bacteria as he is to other irritants such as dust, animal emanations, grasses or weeds. The fact remains that there is no such general acceptance of cold vaccines for the prevention of respiratory disease as there is in the case of diphtheria for example. Bacteria which produce no active immunity can hardly be controlled by passive immune procedures.

That the sulfonamides may be employed in the prevention of respiratory disease may be the next step in preventive medicine. Already sodium sulfathiazole in a 2.5% solution is being employed in the form of nasal sprays and nose drops, and the results so far seem to indicate that this may constitute a satisfactory approach to the problem. There are members of the laity who are taking with a fair degree of regularity the sulfa drugs themselves in small doses. It may be hard on these human guinea pigs if the experiment fails through their intolerance to the drugs, but the layman has often provided us with experimental data through his perhaps injudicious use of medicines. The child who inadvertently swallows without harm an exceptionally large dose of some drug

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CHEMOTHERAPY OF PNEUMONIA*

RUSSEL O. BOWMAN, PH.D.

The Author. *Russel O. Bowman, Ph.D., Research Biochemist, Rhode Island Hospital, Providence.*

IF WE omit the various antisera there are four main types of pure or nearly pure chemicals useful in the treatment of pneumonia:

1. A group of Pittsburgh physicians[1] in 1939 found *hydroxyethylapocupreine* equal in results to antisera in the treatment of pneumococcus pneumonia. The advent of more successful agents, and since the war the lack of quinine, from which the cupreine is derived, has meant no further reports on this form of treatment.

2. *Tyrothricin* and its derivatives *gramicidin* and *tyrocidin* are active against the pneumococcus but they are too toxic for any but local or exterior use.

3. *Penicillin* gives promise of being a very effective, non toxic chemical for treatment of pneumonia of several bacterial origins. Because of limited supplies of it, and its need for military use where other agents are inactive, it will only be used when supplies are available.

4. The *sulfonamide compounds,* particularly *sulfapyridine, sulfathiazole, sulfadiazine* and *sulfamerazine* are the chemicals commonly used for treatment of pneumonia. All of them are effective against beta hemoyltic streptococcus and pneumococcus, and partially effective against staphylococcus and streptococcus viridans pneumonias. They are inactive against virus infections. They are largely responsible for the fall in mortality from pneumonia since 1938. The following discussion will be limited to the use of the sulfonamide compounds and general statements usually applicable to the group will be used, instead of consideration of each drug separately.

All of the sulfonamides, since they are toxic in the human body, as well to bacteria, are detoxified in varying degrees, by combination with acetic acid to form an acetyl derivative. The acetylated compound is inactive against bacteria, and usually much less soluble than the drug from which it is derived.

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Sulfapyridine has fallen into disrepute because of a high incidence of nausea and vomiting. Sulfathiazole is so rapidly absorbed and excreted that it gives a high incidence of renal complication, when the amount being excreted exceeds the low solubility in urine. Sulfadiazine is absorbed and excreted more slowly than sulfathiazole. It was shown to be less toxic for animals, but since somewhat higher amounts are necessary in blood for the same effect, the incidence of renal complications is about the same as for sulfathiazole. Sulfamerazine is excreted slower than sulfadiazine and is more completely absorbed, and its free and acetyl compound are several times more soluble than those for sulfathiazole and sulfadiazine. If it is as effective at the same blood concentration as the other two it should be the drug of choice.

Toxic Reactions

Of the toxic reactions to sulfonamide drugs, *Nausea and vomiting, headache and dizziness* and *crystalluria* (usually acetylated drug) are relatively common. *Drug rash* and *drug fever* and *mild hematuria* occur rarely and when they are present it is advisable to stop the drug and force fluids. *Hemolytic anemia, jaundice (heptatitis) leucopenia with granulocytopenia* have an incidence of less than one case in one hundred. When they occur it is imperative to stop the drug and force fluids. With careful use of the sulfonamides the incidence of *anuria with azotemia* should be less than 1 per cent, but may be higher with careless administration.

This toxic effect appears mostly in dehydrated patients or in those where fluids are neglected, in the older age groups where kidney function is poor before the pneumonia, and where cardiac conditions, malnutrition, sodium intake or blood pressure interfere with urine output.

We have found that an increase in the acetylated drug in the blood occurs before the retention of nitrogen. Where drug determinations are not available to give the tip-off it is imperative to *watch fluid intake and output.* Blockage of the kidney will not occur if urine output is kept at 2500 c.c. per day. Another precaution is to keep the urine alkaline by oral administration of *sodium bicarbonate.* Urine

at pH8 will dissolve nearly three times as much drug as urine at pH6, and it would take three times as much drug by mouth to cause blockage of the kidneys, as at a urine pH of 6. Fever and infection tend to increase acid production and acid excretion, so that without sodium bicarbonate, sodium lactate, or orange juice, the urine would probably have a pH of 5 or 6, and the possibility of renal complications would be high.

Kidney disease, even with azotemia is not a contraindication to sulfonamide therapy, but it is an indication to control dosage, urine acidity and daily volume of urine very carefully.

There is no incompatibility between sulfonamide drugs and sulfate laxatives, eggs, or most general medications. Since they act by competing with or displacing p-aminobenzoic acid in the metabolism of bacteria, one should not give p-aminobenzoic acid or vitamin B complex containing it, or use local anaesthetics related to it (e. g. procaine) since they will prevent the action of the drug.

Sodium salts of the sulfonamides may be used intravenously where oral administration is impossible. They should not be mixed with glucose solutions, blood or plasma, or given subcutaneously because of their strong alkalinity. Sodium sulfapyridine in glucose solution forms a compound which is inactive against bacteria.

Only the laboratory can answer the questions:

1. What amount of drug will be present in blood after any certain dosage?
2. What amount of drug is needed in blood to assure good results?

However, it is known[2] that sulfonamide resistance may develop in vitro and in vivo, so that low dosage should not be used. It is important to *give adequate dosage at first*. If after 48 hours the desired result is not evident and there are 10 mg. of free drug in 100 c.c. of blood, the drug is probably inactive. If there are less than 10 mg. per 100 c.c. the dosage should be increased to obtain this figure. Usually an initial dose of two grams followed by one gram every four hours is adequate for adults. With old people this may be *too high,* and in some cases it is *too little* to treat a bacterial pneumonia successfully.

Dosages of sulfadiazine as high as 8 grams initially, 5 grams in 2 hours and then 4 grams every 4 hours has been given to young males with meningitis.[3] With proper hospital control renal complications were only 6, none fatal, in 134 cases.

[1]W. W. G. Maclachlan, J. M. Johnston, M. M. Bracken and G. E. Crum—The Treatment of pneumococcic pneumonia by hydroxyethylapocupreine. Am. Jour. Med. Sci. *197,* 31-39, 1939.

[2]J. S. Harris and H. I. Kohn-Resistance to sulfanilyl derivatives in vitro and in vivo. Science *92,* 11, 1940.

[3]B. A. Marangoni and V. C. D'Agati—Treatment of 134 cases of meningococcic infection with massive doses of sulfadazine. Am. Jour. Med. Sci. 207, 67-77, 1944.

[4]E. E. Osgood—What the general practitioner should know about the chemotherapy of bacterial infections. Canad. Med. Assn. Jour. 50, 1-8, 1944.

THE SULFONAMIDE TREATMENT OF RESPIRATORY DISEASES IN CHILDHOOD

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demonstrates to us how large a dose can be tolerated.

Rheumatic fever is providing for us an experiment to demonstrate the feasibility of giving sulfonamides to prevent respiratory diseases. Many children and young people are today taking the sulfonamides in daily doses to prevent recurrences so often precipitated by the streptococcus hemolyticus. In this disease, probably another virus disease, we know that the streptococcus infection is often the precursor of rheumatic fever but not the actual cause of the condition. Is it not more than probable that the streptococcus breaks down the natural barriers provided by lymphatic tissue in the throat, so often if not always the focus of infection in this disease, to allow the entrance into the blood stream of the virus of rheumatic fever?

Administration to Rheumatics

In regard to the problem of administering the sulfonamides to rheumatics as an example of what may be ahead of us in the prevention of other respiratory diseases, may I quote from a recent communication from Dr. Homer F. Swift of The Hospital of the Rockefeller Institute for Medical Research? "The use of sulfonamides in rheumatic fever patients, as you know, must be divided into several phases. As far as our experience goes, these drugs are only of value in preventing the hemolytic streptococcal infections which are the precursors of attacks of rheumatic fever. After the streptococcal infection has occurred, they do not prevent the onset of rheumatic attacks. In other words, they are of little value in this respect when given in phase one or two.

We have seen no beneficial effects with them when given to a patient with active rheumatic fever, and in some instances, the patient's symptoms seem to have been made worse by sulfonamides. Their use, therefore, is limited to the prevention of hemolytic streptococcal infections where they have dis-

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GENERAL RECOMMENDATIONS OF WELFARE COMMISSION

(The Journal publishes below the major recommendations made by the State Commission on Public Welfare Institutions after a two year study by authorization of the General Assembly)

The Commission. *Col. Patrick H. Quinn, Chairman; Alex M. Burgess, M.D.; Rev. William R. Clark, O.P.; Clemens J. France; Harry Loeb Jacobs; Mrs. Lucille P. Leonard; Charles A. McDonald, M.D.*

CHAPTER III

Recommendations

I. IN GENERAL

A. *Department of Public Welfare Institutions*

There shall be in the State Government a Department of Public Welfare Institutions. This Department shall have jurisdiction, supervision and control of the following State Public Welfare Institutions and the persons therein:

1. The State Hospital for Mental Diseases located in the City of Cranston comprising the buildings and lands, patients and employees. (At present there are approximately 2788 patients with an appropriation in 1943 of $833,050.)

2. The State Infirmary, to be known hereafter as the "John Clarke Hospital and Medical Center", to occupy the present buildings and also the building now known as the "State Reformatory for Men"; this latter building is to house the State Medical Center. (In the State Infirmary at the present time there are 865 patients and in the winter months the capacity is not adequate. Converting the building now known as the "State Reformatory for Men" will relieve the need of the construction of new buildings for the State Infirmary. The capacity of the Reformatory building is approximately 250 prisoners and therefore the building would be able to accommodate about 250 patients.

3. The State Sanatorium for Tuberculosis located at Wallum Lake and now within the Department of Public Health. (This Hospital contains 458 patients.)

4. The Exeter School, to be renamed the "Gleason School and Hospital", to be enlarged to accommodate 1,000 patients.

(These four medical institutions have a combined population of 4980 and are increasing in population every year.)

5. The State Prison and Providence County Jail, to be known hereafter as the "State Prison, Jail and Reformatory for Men", to occupy the buildings now known as the "State Prison and County Jail". (At the present time there are 230 men in the prison; only 156 in the jail; and but 112 in the State Reformatory for Men. Thus the total population of these three at the present time is 498 prisoners.)

6. The building now used as the State Reformatory for Men, to be abandoned as such and transferred to the John Clarke Hospital, and to be known as the "Medical Center".

7. The State Reformatory for Women, to be known hereafter as the "State Prison, Jail and Reformatory for Women" and to be housed in a new building recommended to be built on land owned by the State in back of the present Oaklawn School for Girls. The building in which the State Reformatory for Women is located to be abandoned as such and to become when remodeled an extension of the criminal insane ward of the Mental Hospital for the housing of defective delinquents who need care, treatment and restraint.

8. The Oaklawn School for Girls, to be called hereafter the "Harriet Ware School for Girls", to remain in its present location.

9. The Sockanosset School for Boys to be called the "Whittemore School for Boys", to remain in its present location. (There are 180 boys in this School.)

(N. B. The present total population of the State Prison and Providence County Jail, the Reformatory for Men, and Reformatory for Women, the Oaklawn School for Girls and the Sockanosset School for Boys is 798. Of this number 678 are males and 120 females

10. The State Home and School, with a population of 131 and an appropriation of $103,690. to be abandoned.

11. The Soldiers' Home at Bristol, with a population of 66 and an appropriation of $57,795. to be abandoned.

These two institutions comprise 197 persons with a combined appropriation of $161,485. The persons herein cared for should be distributed to other institutions in this department; the children who are sick, to the John Clarke Hospital; the children who are mentally defective, to the Gleason School and Hospital; and in the case of children with conduct disorders, to the Whittemore School for Boys, the Harriet Ware School for Girls.

These above named institutions have a total population of 5975. This population is sharply divided into two groups: (1) 798 of this total number are in the corrective institutions; (2) and 5177 persons are in institutions which provide medical supervision, care and treatment. Of the total population of this Department of Public Welfare Institutions 87% are patients and 13% are prisoners. In view of the fact that over 50% of prisoners are admittedly psychotic and therefore present primarily a medical problem, the number of state wards whose condition is not essentially of medical interest is reduced to less than 7%.

The Commission recommends the separation of the State Institutions from the Department of Social Welfare and for many reasons, not least of which is the fact that Welfare services and institutional services are unlike in kind and function. Welfare Services comprise the good-will of society to aid and care for persons in society who, through no fault of their own, need help and guidance. Institutional services, on the other hand, contain those people who are poor, sick or bad, whom society has isolated for care, treatment, or punishment and restraint, for the welfare of the general public as well as the patients and prisoners themselves. The objectives are entirely different. Social Welfare is for persons in society; public welfare is for persons outside of society. Thus, to have Public Welfare a part of Social Welfare is like giving to the Director of Public Aid in Providence, who looks after the poor, the control and supervision of the Police department and the hospitals of the City of Providence.

This Commission is unable to understand why dependent children and other persons who are poor through no fault of their own and are, therefore, receiving State aid, should be cast into the same category with prisoners of all types by being placed under the same management, the same general supervision, and the same sole Director.

B. *Director of the Department*

There shall be a Director of this Department of Public Welfare Institutions appointed by the Governor. The Commission further recommends that insofar as approximately 93% of the population of this department needs medical care, supervision and individual study, that the Director be a physician, a graduate of a recognized medical school, who has had training and experience in the administration of hospitals for not less than ten years; and that in the selection of a Director there should be a countrywide search. The Director of this Department should have a salary commensurate with his medical training and medical and public responsibilities; such salary should be of a definite sum and should not include housing and maintenance. The Director of this Department should not have the right to engage in private practice or to hold any other paid position in the State Government.

* * * * *

E. *Boards of Trustees*

The Commission recommends the establishment of a Board of Trustees for each institution or group of institutions listed in this paragraph. In the last seven years there have been four directors in control and supervision of these State Welfare Institutions. In the last seven years there have been four superintendents of the Mental Hospital. The Commission is of the opinion that a Board of Trustees for an institution, appointed by the method to be recommended (see Appendix VI) will serve to make the administration of an institution more permanent and will have for its primal duty to see that the institution provided by the public fulfills its purpose and needs; and in the exercise of its functions, to be outlined, will act as representatives of the public in the general administration of the institution. There shall be six Boards of Trustees appointed as follows: for (1) The State Hospital for Mental Diseases; (2) The John Clarke Hospital and Medical Center; (3) the Gleason School and Hospital at Exeter; (4) the State Hospital for Tuberculosis; (5) the State Prison, Jail and Reformatory for Men and the State Prison, Jail and Reformatory for Women; and (6) the Whittemore School for Boys and the Harriet Ware School for Girls.

The Commission, therefore, recommends appropriate legislation to accomplish the above mentioned purpose. Such legislation, modeled after a

continued on next page

law now in force in the State of New York, is found in Appendix VI. The Commission recommends its adoption.

F. State Medical Center

1. *Clinics for Chronic Diseases.* The Commission recommends as a part of the John Clarke Hospital and in the building now known as the State "Reformatory for Men" the establishment of a Medical Center. This Medical Center is to be a unit of the John Clarke Hospital. The rules and regulations of this Medical Center to be made according to law by the superintendent of the John Clarke Hospital, subject to approval in a general way by the Director of the Department of Public Welfare Institutions and the Board of Trustees of this Hospital. In this Medical Center there shall be established under the supervision and control of the superintendent research clinics and special clinics. These clinics shall contain (a) a clinic for the study and treatment of patients of the John Clarke Hospital who are suffering with cancer; (b) a clinic for the study of patients who are suffering from chronic arthritis; (c) a clinic for the study of chronic nervous diseases; and (d) such other clinics as may be established by the superintendent of John Clarke Hospital. The purpose and aim of these special clinics is to group together patients of the John Clarke Hospital into the Medical Center for special study and treatment. Patients of this Medical Center are to be admitted to the John Clarke Hospital and at no time directly into this Medical Center without being admitted to the John Clarke Hospital in accordance with its rules and regulations for admission.

2. *State Juvenile Study Clinic.* There shall also be established by the superintendent of the John Clarke Hospital, with the approval of the Director and Board of Trustees, a clinic to be known as the "State Juvenile Study Clinic." This Clinic shall receive male and female residents of Rhode Island who are not over eighteen years of age and who are suffering from disease or disorder of body, mind and conduct. Admission shall be made according to the rules and regulations made by the superintendent of the Hospital and the laws of the State. This Clinic shall have the power and right to retain a person admitted or committed, for a period not in excess of 28 days. Studies are to be conducted, diagnoses made, records to be kept, and recommendations given as to placement, treatment, and education. The Juvenile Study Clinic shall have for a staff, a physician in charge and as many physicians, psychiatrists, psychometrists, social

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SULFONAMIDES IN THE TREATMENT OF THE COMMON DISEASES OF THE UPPER RESPIRATORY TRACT

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azine therapy in patients with beta hemolytic streptococcic infection of the upper respiratory tract.

What of the pneumococcic, influenzal bacillus, and staphylococcic carriers? We have no date on them. There is some evidence, although not conclusive, that sulfadiazine is effective in eliminating meningococcus from the nasopharynx in meningococcic infection. During the past 15 months, 385 cases of meningococcic meningitis and septicemia were treated at the Charles V. Chapin Hospital and only two patients had positive cultures taken before their discharge from the hospital, but the next cultures were negative. Allowing for errors in taking the cultures and in plating them, the result still remains interesting.

One point which is of importance with respect to prophylactic treatment is that the dosage of the drug is more than likely small and inadequate which, if anything, enhances the tolerance of the organisms instead of destroying them.

Thus, the sulfonamides are invaluable in certain bacterial diseases and, when used wisely, are most effective. Their indiscriminate use serves no purpose and may rob the patient of a life-saving measure in his time of need. In diseases of the upper respiratory tract, the sulfonamides are not usually required.

THE SULFONAMIDE TREATMENT OF RESPIRATORY DISEASES IN CHILDHOOD

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tinct value. There is enough accumulated evidence to show that they may be given in small doses over long periods with a minimum of danger. When I say a minimum, I mean that there is still some danger; and certain patients are seen whose reactions are severe enough to indicate the discontinuance of the drug. Doctor Thomas of Baltimore feels that it is safe to give these patients about a gram a day and not follow them unless toxic symptoms appear. In my opinion, it seems that patients receiving such treatment over long periods of time should be seen at intervals in order to determine how they were reacting both as far as beneficial effects are concerned and also as to possible drug toxicity, particularly depression of the blood forming organs.

It is a little difficult to understand the variation in the reports of the frequency of drug toxicity in different groups of patients. Some good observers

say that they are so infrequent that they have no dread of them. Other equally good observers feel as I do that all patients receiving these drugs over long periods should be examined as above indicated."

[1]Cecil, Russell L. et al, Jour. A. M. A. Jan. 1, 1944, "Sulfadiazine in the Treatment of the Common Cold".

[2]Editorial Jour. New England Medical Dec. 9, 1943.

[3]Bowers, Wesley C., Jour. A. M. A. July 20, 1940, "Observations on 793 Cases of Purulent Otitis Media".

[4]Fink and Wilson, Jour. Pediatrics May, 1943.

[5]Jour. A. M. A. Jan. 22, 1944.

ACUTE RESPIRATORY DISEASES

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although a high count usually suggests that bacterial infection is present and that sulfonamides should be used. We have, however, frequently seen normal and even low counts in proved pneumococcus pneumonias and leucocytosis of a moderate degree in patients who resisted sulfonamides and in whom the evidence strongly favored a virus infection. The older the patient the less one should be inclined to sulfonamides and the more care should be given to an adequate intake of fluid and alkalis. The same is true of patients in whom a suspicion of renal disease exists. The younger the patient the more freely the drug may be used. In really doubtful cases where the physician believes that the condition is, or is likely to become, serious and in which the objection of age or possible renal disease is not present a vigorous therapeutic trial of the drug should be made. In these, and in fact in almost all instances in which there is not a very definite improvement after 48 to 72 hours on the drug, particularly if chemical studies have shown that a good blood level has been attained, the drug should be stopped. It also goes almost without saying that the appearance of any of the well known untoward results of drug action such as anaemia, leukopenia, severe rash or fever, or suppression of urine indicates immediate discontinuance.

Choice of Drugs

The drugs of choice, I believe, are sulfamerazine and sulfadiazine. In our clinic we have apparently been unable to attain any higher blood levels with the former than with the latter. In the severe cases 5 grams of the sodium salt should be administered intravenously and treatment by mouth, one gram every four hours, begun at the same time. We are accustomed to use one teaspoonful of sodium bicarbonate (7 to 8 grams) dissolved in one-half glass of water with each oral dose. This has resulted in a urinary pH of from 6 to 10 in most of our patients. The blood level determined after eighteen hours or so is a help in controlling treatment and we believe that in some instances recurrence of fever has taken place while the drug is still being administered because, due to infrequent dosage, a level of not over 5 or 6 mg. has been obtained. This has been noted in the use of sulfamerazine in doses of one gram every eight or even every six hours as recommended by the manufacturers and we have recently been using it as we do sulfadiazine at four hourly intervals. In the average patient in whom a prompt fall in temperatre has taken place it is well to omit the drug after 48 hours of normal or nearly normal temperature.

In pneumonia, even though the case is typical and the indication for sulfonamide treatment clear, it is very important, if possible, to obtain sputum and blood culture before the drug treatment is under way. If this is not done it is usually impossible, after treatment has gone on for several hours, to find a typable pneumococcus in either blood stream or sputum and therefore the use of the proper serum, which in the occasional severe or drug resistant patient may be needed, is impossible.

Indiscriminate Use Condemned

The indiscriminate use of sulfonamides without adequate study of the patient is to be condemned. It has been urged that by their use in virus-caused disease bacterial complications may be prevented. This may be so to a limited extent if large doses of the drug are used for a long enough time, but, in my judgment, the possible harmful effects of these drugs, including renal block, blood changes, nausea, vomiting, rashes and drug fever are greatly outweigh such theoretical advantages. It also must not be forgotten that repeated small and ineffective doses of the drug in the presence of a susceptible organism, tend to render that organism resistant so that the later use of adequate doses will be no longer effective. It is quite possible that if, as the years go on, the drug is widely used in insufficient dosage, a large number of highly resistant strains of pneumococci and other organisms will survive in the community and we will be faced with outbreaks of pneumonia in which as far as sulfonamide treatment is concerned we may find ourselves helpless.

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WELFARE COMMISSION REPORT

In this issue of the JOURNAL is reprinted the general recommendations of the State Commission on Public Welfare Institutions as regards the medical care institutions. This phase of the report warrants the attention of every doctor of medicine in the State. The work of the Commission has been excellently done, and it is to be regretted that the conclusions it has reached have been lessened in general public understanding of them by the filing of two minority reports by members of the Commission.

The Commission had a three-fold purpose. It was created to appraise existing conditions in the State institutions; it was to determine what might be done immediaely towards relieving conditions; and it was to recommend a long-range plan for institutional improvement. The long range planning will necessarily be subject to a great extent to post-war problems as well as the strength of the political leadership of the State in the years ahead. But certainly there should be no delay in relieving some of the present conditions which the clear-cut and sharp appraisal of the non-partisan Commission has revealed.

For too long the idea has persisted that the problem of the state institutions is solved by merely appropriating annually funds which provide for what amounts to minimum maintenance and operation of the establishments. Too long has the interest in the structure of the physical plans overshadowed the work which should and must be done for the unfortunate patients or inmates whose good care rests upon the humanitarian viewpoint of our citizens.

While certain recommendations of the Commission, such as the proposal to create a separate Department of Public Welfare Institutions, may be debatable, they certainly should not be allowed to hide from the view the basic issue revealed by the study. That issue, as we see it, is the provision by appropriation of public welfare funds and otherwise whereby adequate salaries and good housing conditions may be offered to attract highly specialized professional individuals to implement our institutional staffs. A careful study of the State budget by the General Assembly with this thought paramount might well relieve to some extent the present conditions.

With strong professional leadership, employed under civil service regulations and independent of the changes in state political administration, our state institutions might well achieve their true purposes according to highest standards. Otherwise, as the Commission so well states in its report, "the fine buildings and equipment, frequently added to at

great public expense from year to year, in which the individual services to the unfortunate patients or inmates are so poor . . . due to lack of trained personnel . . . from a public welfare standpoint are mere hollow shells."

THE BAR ASSOCIATION ON THE WAGNER ACT

For the past eight months the medical profession of America has militantly led the fight aginst the proposed Wagner-Murray-Dingell act now before Congress. In this legislation the doctors of the nation noted the effort to encroach on the right and liberties of the citizens with the pretext of improvement of the general health of all as the lever with which to win support for the act.

The report, therefore, made by the special committee of the American Bar Association to study and report as to parts of the Wagner Murray bill relating to federal control and regulation of medical practice and hospitalization, and subsequently adopted by the House of Delegates of the Bar Association on February 28, stands as an important document worthy of the attention of doctor and patient alike.

The following significant conclusion was made in the complete analysis by the Bar Association Committee:

CONCLUSION

The American Bar Association is limited to an expression of opinion and judgment with respect to those fields which relate to the administration of justice and which directly affect the safeguards and protection of the rights and liberties of the citizens of this country. Under normal circumstances, therefore, it is not the function of this association to attempt to influence substantive legislation by the Congress of the United States. But when under the pretext of the general welfare legislation is proposed in Congress which either inadvertently or with deliberate subtlety constitutes a direct attack on the rights and liberties of the citizens of this country, it becomes the duty of this association actively to voice its objections, a summary of which is as follows:

1. Local self government must be preserved in our federal system. State governments directly responsible to the will of the people are best adapted to exercise such supervisory control as may be instituted over the health and medical care of our citizens.

2. S. 1161 seeks to invest in the Surgeon General, who is not an elected servant of the people and who is not amenable to their will, the power arbitrarily to make rules and regulations having the force and effect of law which directly affect every home.

3. The measure furnishes the instrumentality by which physicians for their practice, hospitals for their continued existence and citizens for their health and that of their families can be made to serve the purposes of a federal agency.

4. The bill fails to safeguard the rights of patients, citizens, hospitals or doctors with respect to disputes arising or rights denied through the arbitrary or capricious action of one man.

5. The bill fails to provide for any appeal to any court from the action of the Surgeon General.

6. The vicious system whereby administrative officials judge without court review the actions of their subordinates in carrying out orders issued to them is extended in this bill to a point foreign to our system of government and incompatible with the adequate protection of the liberties of the people.

The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered impotent when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear on them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates.

CASH SICKNESS COMMITTEE

The appointment within the past month by Dr. M. H. Sullivan, president of the State Society, of a 10-member Advisory Committee to the state Unemployment Compensation Board to assist in the medical phases of the state Cash Sickness Act should go far towards the solution of some of the existing medical administrative problems of this program.

It is unfortunate that such an advisory committee was not sought by the UCB a year ago. Certainly there was evident cooperation from the start on the part of the medical society leaders, for the presidents of the State Society and the Providence Medical Association in 1942 met with the Board when

the act was first made law. Subsequently the Committee on Medical Economics and the officers of the State Society met with the Board in December, 1942, to review the entire program and to proffer assistance.

With the actual operation of the distribution of benefits on claims for sickness the Board encountered many difficulties of a medical nature which might have been avoided. Failure to include representatives of the State Medical Society in the planning only aggravated a condition which was highlighted by controversy in the daily press last fall. Now that the Board has extended the invitation to Dr. Sullivan to name a statewide committee to assist in an advisory capacity we may hope for a better understanding and a better interpretation of rulings, for the benefit of the workers whose contributions make the disability insurance plan in Rhode Island the only one of its kind in the country.

PORTRAITS OF PAST PRESIDENTS

Editor, Rhode Island Medical Journal:

In the spring of 1943, when Dr. Elihu Wing made the admirable suggestion that we have a portrait painted of our then president, Charlie Gormly, he started a precedent which I think should be continued.

We have always had some fine men as presidents of our state society, and they should likewise be honored, even though many of our past presidents still in active practice might in their modesty be reticent concerning such a procedure. How retroactive this should be remains within the discretion of the society members, but surely those who are living and most assuredly the two men, Fred Hussy and Murray Danforth, who left us last June should be included. Did anyone in this society ever see such courage as that displayed by Murray Danforth, when he arose from his bed to give his short inaugural address at the annual meeting two days before his death? He, himself, must have known that his end was near, but unfalteringly and devotedly as he lived his life, so he carried on to the end. He was world known as an orthopedist.

We have had surgeons of national note, anesthetists known throughout the country, a cardiologist whose work and writing have added much to our knowledge, medical men whose very lives have demonstrated their worth, men perchance who added little to medical literature but whose accomplishments in the community were sufficient guarantee of their virtues.

Certainly there are some families of our past presidents who would unquestionably be glad to contribute a portrait, but in lieu of such a gift, surely by contribution of members enough could be raised to have portraits painted from photographs. This procedure is most satisfactory, the cost is slight, the likeness always the best and such portraits can be painted in a size of 18" x 24", requiring very little wall space in our library and auditorium.

At a recent meeting of the House of Delegates the suggestion was made that what remained from the contribution fund for Dr. Gormly's portrait should be donated to an award for the physician who in the future is chosen to deliver the Charles V. Chapin lecture at the annual state society meeting. I for one would rather have had this sum used for the purpose mentioned in this communication. The medical society itself should furnish from its own treasury the money necessary for the honorary award to the future speakers at our annual meetings. Every member of our society profits by such a lecture, all are interested and should contribute to the cost when paying their dues. The speaker should not be remunerated by our subscriptions to a fund. There are those of us who would be willing to give to cover the cost of portraits of those past living presidents or of those who have left our midst, but later when this task of catching up is over, the society should assume, through its treasury, the cost of painting the portrait from life or from photograph of each future president.

While we are on the subject of honorary portraits, what about some of our secretaries? There is a framed set of resolutions at the right of our coat room to Jim Leech who for twenty years gave his thought, time and withal devoted patience to the affairs of our society. If ever a member of our society deserved a portrait, it is Jim Leech. It should be placed in a conspicuous place with the resolutions beneath.

Since I have known your present secretary he has been devotedly interested in every activity of this society, has given unstintingly of his time, his labor, his knowledge and administrative ability, often to the detriment of his private practice.

Our presidents serve for one year only, our secretaries work on for years, but such is the scheme of life that they go unhonored for their labors,

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RHODE ISLAND STATE DENTAL SOCIETY

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ADULT DENTO-FACIAL REHABILITATION

MORRIS RUMLER LEBOW, D.D.S., Providence, R. I.

THE old adage, "For want of a shoe the horse was lost," may be modernized to, "For want of a tooth all teeth were lost." This sounds like an overstatement; nevertheless it is true. The late Dr. Martin Dewey, a well-known teacher in the field of orthodontics, once remarked that if he had an enemy and wanted to wish him harm, he would wish him to lose one tooth and then let him loose. This enemy would have enough trouble to take care of him for the rest of his life. I questioned the truth of that statement at that time, but after examining some human skulls, together with a life time of clinical observations, I arrived at the same conclusion.

The average layman believes that his permanent teeth are only temporary, and that it is a matter of time only before they are all lost. Nothing could be farther from the truth. As a matter of fact, nature did not intend permanent teeth to be temporary, but to last during an individual's life time.

The question comes to the mind, what happens when a tooth is lost? The answer may be better understood if we compare the human dentition with that of a wooden barrel. Both the dentition and barrel are held together in a similar manner. The wooden barrel is made up of staves which are held together by its contiguity of the staves and by the hoops. If one of the hoops is lost and a stave falls out the entire barrel collapses. In a similar manner the human dentition is made up of individual teeth which are held together by contiguity. The tongue, checks, and lips help to keep them in position. When a tooth is lost and is not immediately replaced by an artificial pontic, there begins to take place a movement of all teeth affected into malposed positions, and finally a malocclusion is thereby created. This is where the vicious circle begins which may finally end with the loss of all teeth. Any artificial dental restorations placed upon these malposed teeth must inevitably end in failure. This is often the reason why some of our best efforts do not succeed. It does not make any difference whether it be a partial plate, a fixed bridge, or a removable bridge, if the cause or the malocclusion is present, it will definitely end in failure.

For a number of years I have taken on some adult cases for orthodontic correction with the idea of preparing them for dental restoration. By that I mean that I have corrected abnormal occlusions for adults in preparation for dental restoration. Invariably this treatment was more than a success, satisfactory to dentist as well as to the patient.

Recenly I have demonstrated some of these results before the Rhode Island State Dental Society. One case shown was completed fourteen years ago and is still going strong; another was completed eight years ago. Every tooth is still there with no gingival envolvement. One case, a woman of thirty-two, manifested a bad case of gingivitis. The correction of the malocclusion also corrected that condition, requiring but minor medication. Another case, a woman twenty-eight years old, with missing molars of both jaws, manifested an extreme maxillary protusion. The protusion was corrected, her dentist replaced the missing molars, and we have restored a very bad mouth to normal usefulness, both from the aesthetic and the utility point of view. This woman showed up two years after completion. She is a most satisfied and grateful patient.

Conditions which require some orthodontic corrections are many and varied. They may vary from

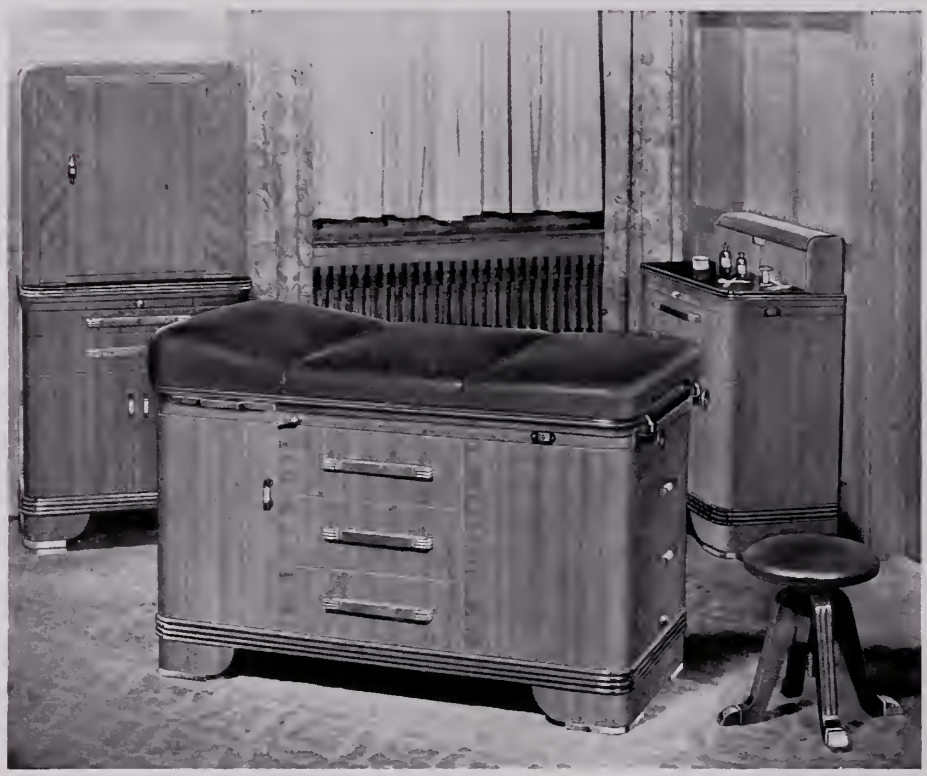
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PROVIDENCE

ADULT DENTO-FACIAL REHABILITATION

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large spaces formed in the incisor region of the mandible, displaced molars, spaced maxillary incisors, unerupted canines and premolars to a gross malocclusion of all teeth. Proper dental restoration calls first for immediate restoration of teeth which have been lost by extraction; secondly, when teeth have shifted into malposition, it calls for orthodontic correction before dental restorations are undertaken. Adult orthodontics must of necessity be limited as to both its scope and to its time of treatment. One cannot expect an adult to wear appliances for a number of years as is often the case with juveniles.

One of the benefits not ordinarily recognized is the fact that orthodontic procedures induce the breaking down of the old alveolar process which in turn is replaced by a new one. The final and beneficial result is a new alveolar process supporting old teeth in an older person. If we could only rebuild our hearts and blood vessels in the same manner as we do the alveolar process, what a boon it would be for mankind!

Conclusions

1. Teeth lost by extraction must be immediately replaced. This is to prevent the dentition from lapsing into malpositions.
2. Adult orthodontics is practical, irrespective of age.
3. Limited orthodontics is indicated in some cases as a preliminary treatment for successful dental restorations.
4. Orthodontic procedures rebuild the alveolar process and invigorate the supporting structures of the teeth.

* * * * * * *

COMMITTEE APPOINTMENTS FOR 1944

ANNOUNCEMENT of the appointments to serve on the committees of the State Dental Society for 1944 has been made by President Arthur M. Dring as follows:

COMMITTEE ON DENTAL ETHICS AND DEPORTMENT

Dr. F. H. Ackrill, Chairman, Providence; Dr. R. L. Webster, Providence; Dr. E. C. Morin, Pawtucket; Dr. C. F. Cannon, Providence; Dr. A. A. Albert, Pawtucket; Dr. T. N. Panaretos, Pawtucket; Dr. J. F. Keighley, Providence; and Dr. G. J. Denicourt, Cranston.

DENTAL-MEDICAL COMMITTEE

Dr. M. A. Denby, Chairman, Warren; Dr. C. J. Smith, Providence; Dr. E. Gill, Providence; Dr. F. J. Canning, Providence; Dr. I. G. Schaffer, Newport; Dr. M. R. LeBow, Providence; and Dr. I. O. Atwood, Providence.

COMMITTEE ON DENTAL LEGISLATION

Dr. A. A. Albert, Chairman, Pawtucket; Dr. P. J. Conley, West Warwick; Dr. T. W. Clune, Cranston; Dr. D. C. Dove, Westerly; and Dr. E. A. Lynaugh, Pascoag.

COMMITTEE ON ORAL HYGIENE-PUBLIC HEALTH

Dr. H. McKanna, Chairman, West Warwick; Dr. T. W. Clune, Cranston; Dr. F. A. Corbett, Newport; Dr. H. J. Pearce, Providence; Dr. A. J. Kershaw, West Warwick; Dr. L. E. Deslandes, Providence; and Dr. B. C. Friedman, Newport.

COMMITTEE ON THE PRESIDENT'S ADDRESS

Dr. E. B. Keighley, Chairman, Pawtucket; Dr. W. S. Gee, Jr., West Warwick; and Dr. A. Johnston, Warren.

continued on page 143

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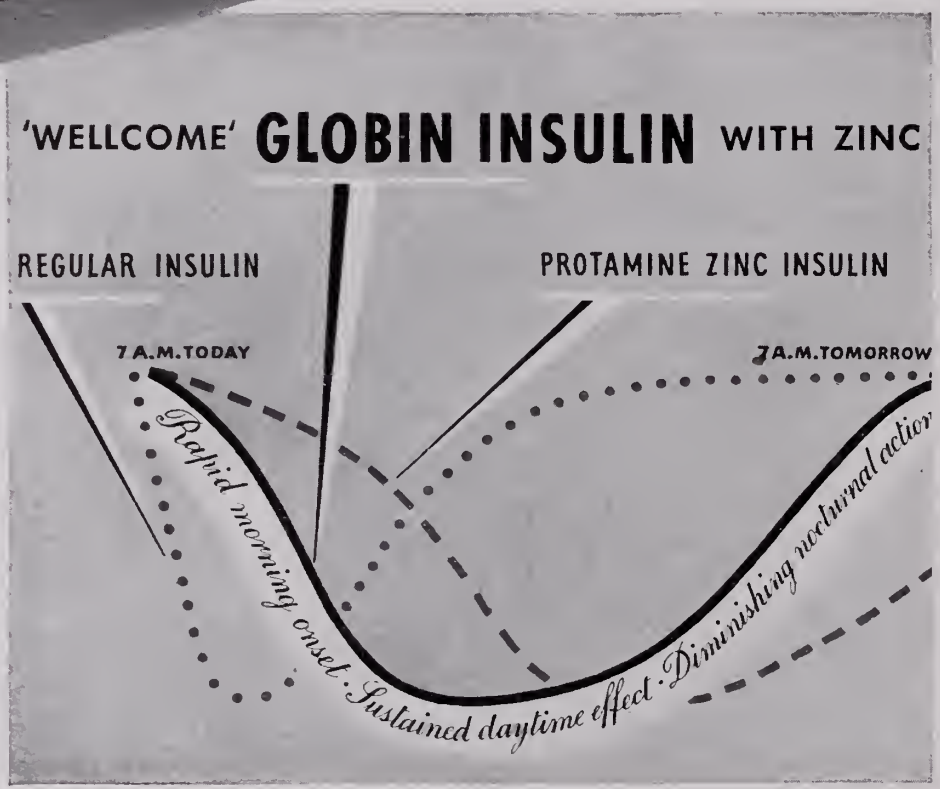
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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., Chairman; Herbert E. Harris, M.D.; Stanley D. Davies, M.D.; Michael H. Sullivan, M.D.; William P. Buffum, M.D.

THE attention of all physicians in Rhode Island is again called to the form of Certificate of Availability reproduced elsewhere in this issue.

It is essential for physicians to completely fill out all parts of this blank. We fully realize these details add an additional load of paper work on an already overburdened physician, but it also takes the responsibility of deciding whether or not the patient is entitled to a change of job off the physician's shoulders. All the physician has to do is to state the case honestly and fairly. Then the patient's welfare is in the hands of the War Manpower Commission.

We have been commended by the American Medical Association and other states for the form. This method of handling the medical aspect of the certificate of availability has received favorable comment from government officials in Washington, as well as medical societies throughout the country who have asked to see copies of this blank. Your cooperation is earnestly solicited.

INDUSTRIAL HEALTH CONFERENCE

The Sixth Annual Congress of Industrial Health was held at the Palmer House, Chicago, February 15th and 16th. Rhode Islanders in attendance were Drs. Charles Farrell, Robert T. Henry, and James P. Deery. That Industrial Medicine is assuming a more and more important place in medical practice was clearly evidenced at this meeting. Papers and discussions covered a range of subjects from the field of preventive medicine to the consideration of post-war industrial health. Newer developments in occupational medicine were discussed and plans for an Institute of Industrial Health at Wayne University were outlined in detail. This is indeed an ambitious undertaking. A further and full report should be available soon. A visual service for small manufacturing plants was given consideration along with the conquest of tuberculosis in industry. The relationships of medicine-labor-management in industry in harmonious cooperation was reported from Philadelphia. Nearly every phase of Industrial Medical practice from malnutrition to newer developments of workmen's compensation disability evaluation was discussed. One of the most interesting symposiums of the meeting was that regarding the rehabilitation and reemployment of the disabled. Everybody who attended felt that this was really a first step forward.

Following the American Medical Association Council of Industrial Health meeting in Chicago, the New England Conference of Industrial Physicians and Surgeons had their regional conference in Boston on February 23rd. Drs. John Kenney, Stanley Sprague, Robert T. Henry and James P. Deery attended from Rhode Island.

RHODE ISLAND ANNUAL MEETING

The Annual Meeting of the Rhode Island Society of Industrial Physicians and Surgeons will be held at the Rhode Island Medical Library on May 23, 1944, just one day previous to the Meeting of the Rhode Island Medical Society. Featured speakers have already been engaged and plans for an elaborate program are well under way. Mark the date on your calendar now!

OFFICIAL RECOGNITION GIVEN

The Rhode Island Society of Industrial Physicians and Surgeons has been accepted as a section of the New England Conference of Industrial Physicians and Surgeons. This means that the active members of the Rhode Island Society who are eligible for full active membership in the New England Conference automatically become members of the American Association of Industrial Physicians and Surgeons through the component Society. Those of the group in the Rhode Island Society who have not been in industrial practice for three years, or have not been out of medical school for five years, or who do not do fifty per cent of their work in industry, will be eligible for an Associate membership in the New England Conference. Further details will be presented at the next meeting. The important fact is that we are now affiliated with the American Association

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OFFICIAL RECOGNITION GIVEN

continued from page 129

of Industrial Physicians and Surgeons through the New England Conference which is a component Society of the national organization.

The 1944 Meeting of the American Association of Industrial Physicians and Surgeons will be held in St. Louis, May 11th to 14th, at the New Jefferson Hotel. The American Association of Industrial Nurses will hold sessions May 12-13 and 14th. The New Jefferson Hotel is official headquarters and reservations should be made early.

USE OF COLD VACCINES

The American Medical Association reports that there is an increase in the prescription and sale of cold vaccine. It is important to remember that there is no recognized scientific evidence of the value of these preparations. Industrial physicians should exercise care in the promiscuous prescribing of cold vaccines. An excellent article appears in the February 26, 1944 issue of the Journal of the American Medical Association, page 555, by McGee, Andes, Plume, and Hinton.

PORTRAITS OF PAST PRESIDENTS

continued from page 124

always much more intense than that demanded of our presidents. I offer this suggestion, Mr. Editor, with the whole-hearted fervor of one who never expects to be the president of the Rhode Island Medical Society. We are indeed a busy and consequently an unemotional group. Let's stir up our sentiment a bit. It is a good tonic for the soul.

Respectfully yours,

HENRY E. UTTER, M.D.

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Objective Signs	Subjective Symptoms

Diagnosis

Specific reasons why applicant cannot continue present employment

Advantages of prospective employment in regard to this applicant

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Approved by Committee on Industrial Health — R. I. Medical Society

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FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street Providence

MEETING OF HOUSE OF DELEGATES

At the January meeting of the House of Delegates, held at the medical Library on January 27, the following actions were taken:

ANNUAL MEETING: The dates for the 1944 annual meeting of the Rhode Island Medical Society were officially set for Wednesday, May 24 and Thursday, May 25, the sessions to be held at Providence.

C. V. CHAPIN ORATION FUND: The report of the Committee on the Charles V. Chapin Oration Fund was received and placed on file. The Committee was also empowered to act to accumulate the sum of money suggested by its proposal.

DELEGATES TO THE A. M. A.: The House unanimously elected Dr. Alex M. Burgess of Providence as its delegate to the House of Delegates of the American Medical Association, and Dr. William P. Buffum of Providence, as alternate delegate.

APPOINTIVE COMMITTEES: The House adopted the recommendation of the Council that the Appointive Committees of the Society be named at the time of the Annual Meeting to serve for the ensuing 12 month period, and that the present appointive committees be continued in office until May, 1944.

INDUSTRIAL PHYSICIANS MEETING: The House voted that the Rhode Island Society of Industrial Physicians and Surgeons be allowed the use of the Medical Library building for the day preceding the Annual Meeting of the Rhode Island Medical Society—Tuesday, May 23—for the purpose of holding the annual meeting of that organization.

VOLUNTARY HEALTH COUNCIL: After lengthy discussion of the proposal for a statewide voluntary health council the House moved the approval of the proposal made by Dr. Emery M. Porter for a statewide Voluntary Health Council as outlined by him in his address to the Providence Medical Association, and further, the House "acquiesced" in the Governor's suggestion that he appoint the Council.

The House also adopted a motion that the Society's representatives on the Voluntary Health Council report to the House of Delegates at stated intervals as to the progress made in the studies.

MEDICAL CARE OF INDIGENT: The report of Dr. Peter F. Harrington, chairman of the Committee on Public Welfare, relative to a plan put into operation by the state department of social welfare in East Providence on a trial basis, was accepted and placed on file.

RED CROSS AGREEMENT

Gentlemen:

The Home Service Department of the American Red Cross is constantly in touch with many of your members, asking for verification for the need for emergency furlough in servicemen's homes when there is serious illness.

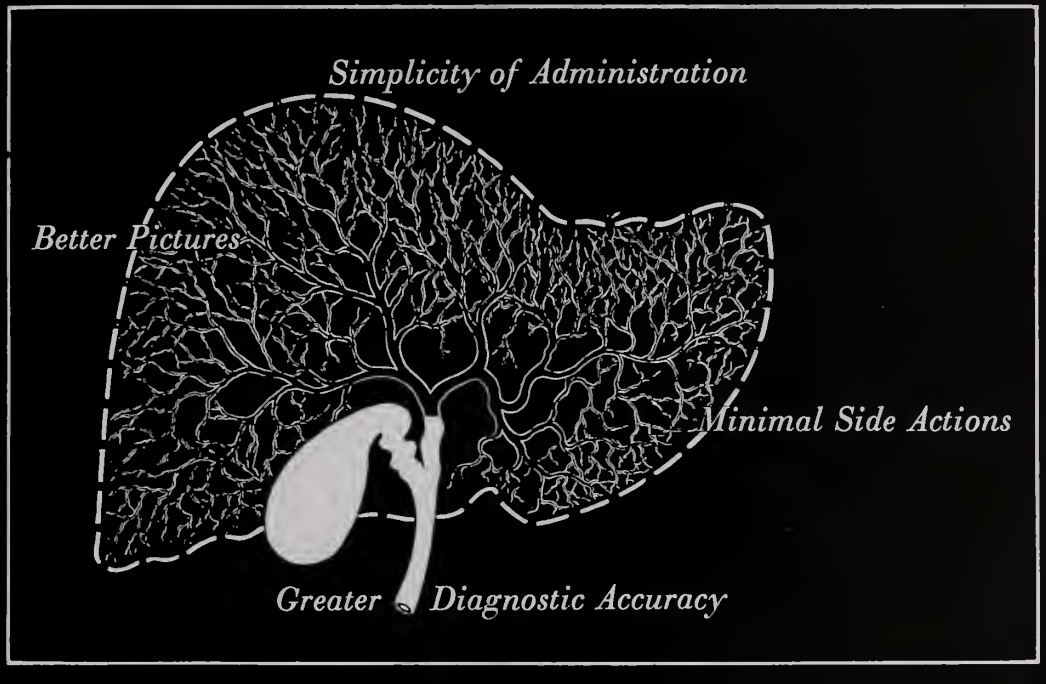
In behalf of the Department I wish to extend my sincere appreciation for the courtesy and consideration which you give the members of this Staff in answering their many calls. We know that this is an added burden in your very busy lives. On the other hand, it is the only means of enabling a soldier to come home when there is serious illness in his immediate family.

It has been brought to my attention that many times servicemen's families and the servicemen themselves are in need of medical attention; the Red Cross would appreciate having some agreement with the Rhode Island Medical Society, so that when we authorize a family to call in a doctor of their own choosing, that the doctor will feel free to bill us for his services. As we understand it there is a similar agreement with the Department of Public Welfare and we believe their charges are $2. for an office call and $3. for a home visit.

continued on page 141

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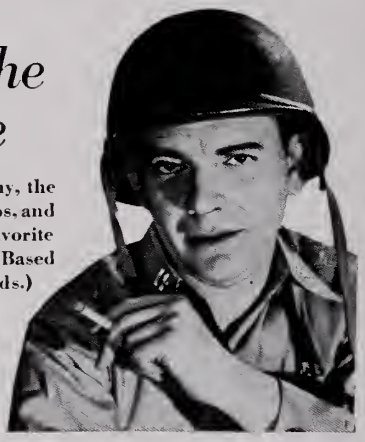
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New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.



The JOURNAL publishes below a list of the members of the Rhode Island Medical Society who are serving with the armed forces of the United States. Every effort has been made to make this list complete and accurate. However, there is likelihood of error due to changes in commissions of which we are not informed. The JOURNAL urges that its readers notify it of any corrections or additions to this list so that subsequent displays may be accurate, and also that the official records of the Society may be complete. . . . *The Editors.*

Capt. Freeman B. Agnelli
Major Simon Albert
Capt. Richard E. Allen
Lt. C. Thomas Angelone
Capt. Michael Arciero
Comdr. Robert Baldridge
Lt. Richard Baronian
Major J. Murray Beardsley
Capt. Louis I. Beaudoin
Capt. Irving Beck
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Capt. Anacleto Berrillo
Lt. Col. Clarence E. Bird
Capt. E. Wade Bishop
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Major Henry A. Campbell
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Capt. Samuel D. Clark
Lt. Paul Cohen
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Major Frank B. Cutts
Capt. Morgan Cutts
Capt. Edward G. Damarjian
Lt. Harry E. Darrah
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Lt. (j.g.) Charles S. Dotterer
Capt. Robert W. Drew
Lt. (j.g.) Walter Durkin
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Capt. James T. Fallon
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continued on next page

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DISTRICT SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

The annual meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday night, February 1, 1944, at 8:30 P. M. Dr. Louis E. Burns, President, presided. There was no unfinished business.

Dr. Charles Dotterer reported as a delegate of the recent meeting of the House of Delegates in Providence on the proposed Medical Health program in the state, and the Governor's report on the proposed Health Council. The communication was received.

Election of officers for the ensuing year resulted in the following members being elected:

President	CHARLES S. DOTTERER, M.D.
1st vice-president	WILLIAM A. STOOPS, M.D.
2nd vice-president	ALFRED M. TARTAGLINO, M.D.
Secretary	PHILEMON P. CIARLA, M.D.
Treasurer	NORBERT U. ZIELINSKI, M.D.
Delegates	JAMES CALLAHAN, M.D. SAMUEL ADELSON, M.D.
Councillor	NORMAN MACLEOD, M.D.
Censors	DOUGLAS JACOBY, M.D. JOHN A. YOUNG, M.D.

Dr. Burns introduced the speaker of the evening, Lt. Comdr. Wesley Buddington, MC, USNR, who chose as his subject, "*Management of Common Urological Problems.*" The highlights of his presentation are summarized as follows:

Renal Calculi often results in much pain, and is often a real emergency; these calculi usually start in the kidney and very often lodge in the ureter. Due to the disproportion of the stone to the lumen of the ureter there is a contraction of the smooth muscle and consequent pain.

Urine is a watery solution of colloids and crystalloids. The nucleus of the calculi starts with the salts of the urine. Due to stasis, there is a precipitation of these salts which occurs faster than would happen when there is a smoothly running stream of urine. Another cause is infection, as from a streptococci throat, toxins being excreted through the blood stream, and excreted in the urine forming a local infection of the kidney tract as in pyelitis, etc. Calculi can also be caused by a hyperexcretory condition with an excess of calcium, etc., being thrown off in the urine as would occur in cases of parathyroid diseases. Another common cause is sulfonamide therapy. It can also be caused by avitaminosis, usually due to a lack of vitamin A which inhibits the epithelium of the urinary tract.

Diagnosis. RENAL CALCULI.

1. This is usually easy. Pain very often radiates down the flank to the bladder and sometimes to the legs and loins. In some cases, however, the pain may be confused with infectious conditions of the chest and be mistaken for a pulmonary condition.

2. Gastro-intestinal type which begins with nausea, vomiting, abdominal distention with fever, the patient being very tender over the kidney area.

3. X-ray is the most useful item as most of the stones will show.

4. Intravenous pyelogram. This is very helpful, but, however, they should not supplant cystoscopy.

5. Cystoscopy. A very important procedure.

6. Careful urine examination, including cultures, etc.

Treatment

A patient with renal calculi should never be dismissed. It is not always necessary to remove all stones but patient should be watched for possible kidney damage.

1. Morphine sulphate and atropine hypos for relief of pain very often moves the stone and urine gets through. The speaker does not believe in so-called morphine anuria or reflex anuria. In cases where this occurs it is well to check for possible stone obstruction in other kidney tract.

2. Fluids are very important as an adjunct as they control infection and relieve patient. 3000 to 4000 c.c. daily given parenterally.

3. Every one or two days it is well to do an I. V. pyelogram if the symptoms persist. Next a cystoscopy should be done. The catheters may be left in the ureter thus often giving relief by promoting drainage.

Later Treatment

1. Operative.

Urethral dilation very often helps.

Reasons for Operation.

1. To relieve persistent pain.

continued on next page

2. Persistent hemorrhage.
3. Infection behind the stone.
4. Loss of renal function.

If the patient is properly treated kidneys come back a great deal after pressure and infection are controlled.

"Dissolution of stones" method is not of much value as a rule, but there is a preparation called Sol. G. which in the hands of some operators has had some success in so far as this solution is less irritating to the ureter. Kaiser improved upon this solution by using urea solution with the Sol. G. alternately and thus was able to dissolve more stones.

Other Treatment

Diets help to prevent further calculi. Use either acid ash or alkaline ash, depending upon the type of stone found.

The most important single thing for preventing recurrent calculi is a high fluid intake for life as soon as the ureters are free.

The speaker mentioned a few words on the use of penicillin in infections resistant to sulfonamides, particularly in the case of specific urethritis; and a series of about 30 cases giving 20,000 units intramuscularly every four hours for five doses, he had no known failures.

There was a general discussion following the presentation in which most of the members took part.

The Society was honored in having Capt. Mills, MC, USN., Commandant of the Newport Naval Hospital, present as a guest. Capt. Mills expressed his pleasure at being present and he participated in the discussion.

A rising vote of thanks was extended to the speaker.

The meeting adjourned at 10:35 P. M., and a collation was then served.

ALFRED M. TARTAGLINO, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The monthly meeting of the Pawtucket Medical Association was held at the Memorial Hospital on Thursday, February 17.

Vice-president Edward Trainor presided. The report of the nominating committee was read by Dr. James L. Wheaton, chairman. The following slate of nominees was presented:

President—Edward H. Trainor, M.D.
Vice-President—Orland F. Smith, M.D.
Secretary—William N. Kalcounos, M.D.
Treasurer—Laurence A. Senseman, M.D.
Standing Committee—Armand Bertini, M.D.
Councillor—James L. Wheaton, M.D.
Delegates—J. Lincoln Turner, M.D.
Stanley Sprague, M.D.
Walter J. Dufresne, M.D.
Earl J. Mara, M.D.

Election of officers will take place at the Annual Meeting which will be held next month. The following committee was appointed to take charge of this meeting: Dr. Robert T. Henry, chairman, to be assisted by Dr. Walter J. Dufresne and Dr. Armand A. Bertini.

MARY-ELAINE J. ROHR, M.D.

PROVIDENCE MEDICAL ASSOCIATION

A joint meeting of the Providence Medical Association and the Rhode Island Medical Society was held at the Medical Library on Monday, February 7, 1944.

Dr. Albert H. Jackvony, presiding officer, announced that the reading of the minutes of the previous meeting would be omitted unless there was objection to such action.

The Secretary read a communication from the Rhode Island Nutrition Association and also a communication from Brown University announcing the Sigma Psi lecture on the "Modern Treatment of Burns" to be given by Dr. Aldrich of the Boston City Hospital on March 13th.

The Secretary reported for the Executive Committee as follows:

1. The Annual Report of the Medical Milk Commission of the Association audited by a professional auditing service, was accepted and placed on file.

2. The Committee moved that the Association not hold a case report contest during 1944 because of the fact that the internes are serving limited time at the hospitals and are burdened with much work.

3. The Committee moved that the resolution passed by the Association at the January meeting relative to the exclusion of certain medical services from any hospitalization contracts should be re-submitted to the House of Delegates of the Rhode Island Medical Society at its meeting in May.

4. The Committee moved to recommend to the Association that it purchase from its operating fund a United States Treasury Certificate in the amount of $1,000 in the name of the Providence Medical Association.

continued on page 141



C. T.

CHOLA-K

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- Obstructive Jaundice
- Hemorrhagic state associated with Primary Hepatic Disease
- Hemorrhagic conditions of Ulcerative Colitis, Sprue and Celiac Disease
- Hypoprothrombinemia of the Newborn

References

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* *Laryngoscope, Feb. 1935, Vol XLV, No. 2, 149-154*

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DISTRICT SOCIETY MEETINGS

continued from page 138

The report of the Executive Committee and the recommendations therein was adopted.

The Secretary reported that the Executive Committee recommended for election to active membership Dr. Arthur B. Cuddy and Dr. Israel Kapnick. Both applicants were unanimously elected.

The President announced that he had appointed Dr. Louis I. Kramer and Dr. Ezra Sharp to prepare the obituary tribute to the late Dr. Irving Blazar, and Dr. J. J. Vallone and Dr. George Dwyer to prepare the tribute to the late Dr. George Mankis.

The President anounced that representatives of Winthrop Chemical Company, Eli Lilly & Company, Smith-Holden and the Parke, Davis Company were present with exhibits in the reading room by invitation of the Providence Medical Association, and he stated that the representatives of these companies would be pleased to discuss their products with any doctors after the meeting.

The business of the Providence Medical Association being completed, Dr. Jackvony adjourned the session so that the Association might join with the State Medical Society in its anual mid-winter meeting.

Dr. Michael H. Sullivan, President of the Rhode Island Medical Society, introduced the speakers for the scientific presentation which was a panel discussion on "Acute Diseases of the Respiratory Tract", under the chairmanship of Dr. Alex M. Burgess. The other members of the panel discussion were Dr. Henry E. Utter, Dr. Kalei K. Gregory, and Russel O. Bowman, Ph.D., Biochemist at Rhode Island Hospital.

Attendance 115. Collation was served.

FRANK W. DIMMITT, M.D., *Secretary*

FROM THE SECRETARY'S DESK

continued from page 132

If this arrangement is satisfactory to the Rhode Island Medical Society, we would like to establish it as a policy.

Very truly yours,

JOSEPH H. GAINER,

JHG:GG *Home Service Chairman.*

(At the January meeting of the council of the Rhode Island Medical Society official approval was given to the arrangement suggested in the above communication from the American Red Cross. All members of the Society are urged to cooperate in this plan of the Red Cross to assist in the payment of medical care for the needy families of servicemen.)

APPRECIATION FROM DETAIL MEN

Dear Mr. Farrell:

At a recent meeting of the Traveling Men's Auxiliary of the Rhode Island Pharmaceutical Association it was voted to have the Secretary send a letter of thanks and appreciation to the Rhode Island Medical Society for the many courtesies extended to our members during these busy days.

Our organization is composed largely of representatives of the various pharmaceutical manufacturers and all of us, in our daily contacts with physicians, have become fully cognizant of the increase in the number of patients and the consequent increase in demands made upon the members of your society for their precious time.

Despite this pressure of time, we have all been graciously received on our visits with your members.

We greatly appreciate this and extend to you our many thanks.

Cordially yours,

NEIL CONNOLLY, *Secretary.*

CASH SICKNESS ACT COMMITTEE

An invitation from the Unemployment Compensation Board to the Society to appoint an advisory committee to advise the Board on medical phases of the Cash Sickness Act was received within the past month. A committee, statewide in representation, was named immediately by Dr. Michael H. Sullivan, and this new committee has already met in conference with the U.C. Board. The personnel of the committee is as follows:

HERMAN C. PITTS, M.D., *Chairman*, 68 Brown Street, Providence.

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ALEX M. BURGESS, M.D., 454 Angell Street, Providence

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DENTAL SOCIETY COMMITTEES

continued from page 127

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COMMITTEE ON NECROLOGY

Dr. W. A. Morinville, Pawtucket; Dr. J. J. Clancy, East Providence; and Dr. T. P. Fogarty, Woonsocket.

COMMITTEE ON PUBLICATIONS

Dr. N. Fortier, Chairman, Pawtucket; Dr. C. F. McKivergan, Providence; Dr. A. L. Midgley, Providence; and Dr. W. F. Tompkins, Providence.

COMMITTEE ON CENSORSHIP— MEMBERSHIP

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AT THE CHICAGO MEETING

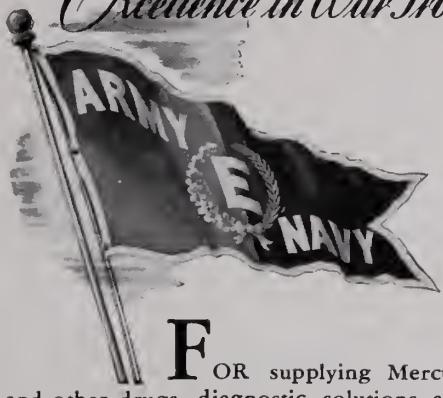
Dr. Norman H. Fortier, of Pawtucket, was Rhode Island's representative at the very successful 80th annual midwinter meeting of the Chicago Dental Society last month.

NECROLOGY

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Died, February 10, 1944

Dr. Albert J. Pobirs of Providence
Died, February 24, 1944

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WELFARE COMMISSION RECOMMENDATION

continued from page 120

workers, school workers, and clerks as necessary. All children before admission to the Gleason School and Hospital and the Whittemore School for Boys and the Harriet Ware School for Girls should be studied in this Clinic whenever this is possible. All cases committed by the courts shall be adequately studied and opinions given but in no case shall any physician or worker in this Clinic be otherwise than a non-partisan witness if called to testify in the case of a person studied in this Clinic and all fees for such testimony shall be paid to the State.

The Policy of this State Juvenile Clinic shall always be for the purpose of study, diagnosis, prognosis, and placement of youthful citizens who are beginning to show evidence of poor health or bad conduct, in the home, on the street, or in the school; or whose condition suggests early mental disorder. In addition to the functions above enumerated, the Clinic shall maintain social-educational and medical interests in the patients who have been studied and placed in the John Clarke Hospital, the Gleason School and Hospital, the Whittemore School for Boys, and the Harriet Ware School for Girls. It is not the purpose of this Clinic to compete with outside physicians or institutions, with problem clinics or child guidance clinics, but to supplement the work of other clinics for more adequate studies.

It is manifest that a State Juvenile Study Clinic under medical supervision is more pertinent to the study of juvenile disorders than one where corrective measures only are suggested. The Study Clinic conducted in accordance with the aims and policies mentioned can be a valuable reference clinic for the twelve District Courts and the five Superior Courts. One of the main purposes of this State Juvenile Study Clinic is to be a help to the Courts. Its work, carried out in the manner suggested, would render the establishment of a separate Juvenile Court unnecessary.

G. Internal Organization—Administrative Councils

The internal administration of every one of our Public Welfare Institutions has been by the "grapevine". Our State Institutions began as farms and developed into medical and correctional institutions, and today the policy appears to be a return to the farms with the "grapevine" as the administrative method within and without. The "grapevine" should be uprooted and a modern internal administrative organization established. This new organization should be departmental with definite duties and responsibilities. It should be composed of chiefs of the various services.

In every one of our institutions, both medical and correctional, this type of organization should be established, modified according to the purpose of the specific institution in question. By such a definite departmental set-up, an organization quite analagous to that of the State Government with its Departments and Directors will be created. Such an arrangement assures the placing and fixing of responsibility. It also allows mutual aid and cooperation between comparable departments of different hospitals. For example, the clinical director of the State Hospital for Mental Diseases could get very real assistance in the care of his patients who suffer from tuberculosis as a complication (and there are many such) from the clinical director of the Sanatorium at Wallum Lake.

The following organization is recommended:

1. *Medical Institutions*

a. *Executive Officers* (Superintendent, Assistant Superintendent, Clinical Director, Business Agent, Pathologist.)

b. *Visiting Staff*. There should be a visiting staff appointed by the superintendent with the approval of the board of trustees. This staff shall receive a stipend and transportation. The staff should comprise physicians, surgeons, and appropriate specialists. These visiting men should not be mere consultants but should aid in the study, diagnosis, and treatment of patients. This policy of giving the visiting staff greater power and duties than heretofore has been the custom will serve to improve the progress and speed the release of patients. The staff will bring in wide experience gained in general hospitals and continue the treatment of many patients who have previously been studied in other hospitals in the State. In view of the obvious fact that in our State hospitals are patients with chronic diseases, the acute stages of which were in very many instances observed and treated in the general hospitals of the State, it will be of the greatest benefit to these patients to have as members of the visiting staff doctors who are also serving on the staffs of the general hospitals from which they come.

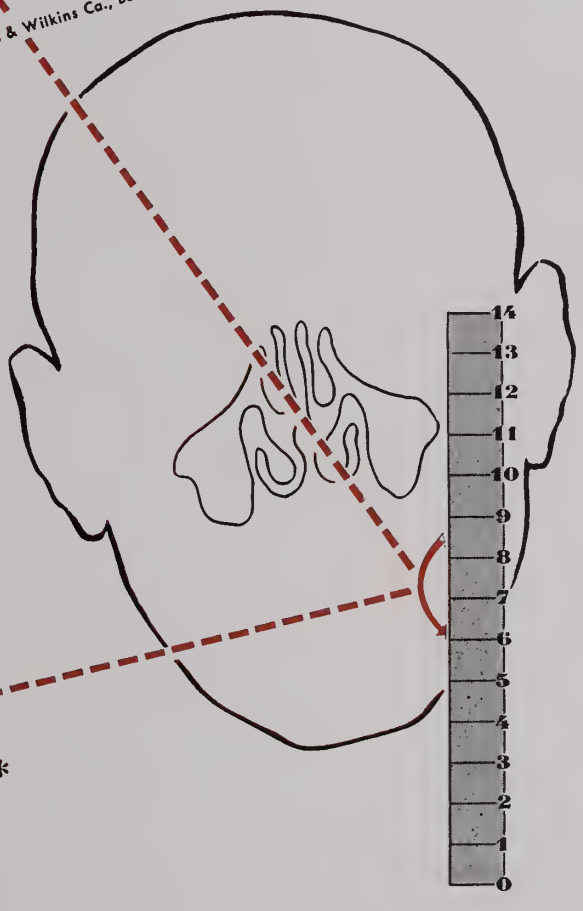
c. *Hospital Staff*. (1) Medical service, (2) Nursing service, (3) Social service, (4) Occupational and education service, (5) Pathological service, (6) Business service, (7) Maintenance service, (8) Steward of operations, (9) Religious service, (10) Such other services as may be organized

continued on page 146

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1. Fabricant, N. D., Nasal Medication, Williams & Wilkins Co., Balt., Md.—1942



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WELFARE COMMISSION RECOMMENDATIONS

continued from page 144

by the superintendent subject to the approval of the board of trustees.

d. *Administrative Council.* Of every one of these departments there shall be a chief selected by the superintendent with due regard to education and standards attained by the individuals. The chiefs of the services above enumerated shall be members of the hospital administrative council. The superintendent and the clinical director shall also be members and, in addition to the above, one member of the board of trustees and one from the visiting staff. The superintendent or his appointed representative shall be chairman.

The primary function of this administrative council is to consider what is best for the individual patient. The patient's disease, his progress in the institution, and his social life on release shall be subjects for discussion by the group. Meetings shall be held at stated intervals, attendance records shall be kept and records of the discussion shall be made on a form provided for that purpose. All actions of the council concerning individual patients shall be of a confidential nature and the records of such actions shall not be available to the public. Access to such records shall be obtained only in accordance with rules and regulations made by the superintendent and approved by the board of trustees. The main reason for which this Commission recommends the establishment of such an administrative council is to bring to the surface department organization, which can be observed and studied and the dignity of whose actions can be appreciated, to make the administration of our hospitals an open book, and to prevent the secret wielding of power by unauthorized employees within the institutions which constitutes the "grapevine".

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NUTRITIONAL ANEMIA IN INFANTS

REASONS FOR EARLY FEEDING OF PABLUM (OR PABENA)

1. The infant's initial store of iron is rapidly depleted during the first months of life. (Mackay,[1] Elvehjem[2]). About 30% of the iron freed from the hemoglobin during the first two months is lost, and while hemoglobin destruction takes place, all infants are in negative iron balance. (Jeans,[3] and Usher, et al.[4]).

2. During the early months of life the infant obtains very little iron from milk — 1.44 mg. per day from the average bottle formula of 20 ounces or possibly 1.7 mg. per day from 28 ounces of breast milk. (Holt,[5] Jeans[3]). The incidence of nutritional anemia has been found to be high among infants confined largely to a diet of cow's milk. (Davidson, et al.[6] Usher, et al.,[4] Mackay[1]).

For these reasons and also because of the low hemoglobin values so frequent among pregnant and nursing mothers (Strauss,[7] and Gottlieb and Streon[8]), the pediatric trend is constantly toward the addition of iron-containing foods at an early age, both to normal infants and those with pylorospasm. (Neff,[9] Blatt,[10] Brennemann,[11] Monypenny[12]).

THE CHOICE OF THE IRON-CONTAINING FOOD

1. Many foods high in iron actually add very little to the diet because much of the mineral is lost in cooking or because the amount fed is necessarily small or because the food has a high percentage of water. Strained spinach, for instance, contains only 1 to 1.4 mg. of iron per 100 Gm. (Bridges[13]).

2. To be effective, food iron should be soluble. Some foods fairly high in total iron are low in soluble iron. Thus egg yolk and liver have less soluble iron than does farina, which is very low in total iron. (Summerfeldt[14]). Oxalate-containing leafy vegetables are low in soluble iron and appear not to be well utilized as a source of iron by infants. (Kohler, et al.,[15] and Stearns[16]).

3. **Pablum (and Pabena) are high both in total iron (30 mg. per 100 Gm.) and soluble iron (7.8 mg. per 100 Gm.) and can be fed in significant amounts at an early age, without digestive upsets. (Blatt,[10] Monypenny[12]). Clinical studies of sick and well babies have shown Pablum to be of value in raising hemoglobin values (Crimm, et al.,[17] Summerfeldt and Ross[18]), even when egg yolk and spinach were not effective (Stearns[16]).**

Pablum, a palatable mixed cereal food, vitamin and mineral enriched, and cooked thoroughly and dried, consists of wheatmeal (farina), oatmeal, wheat embryo, cornmeal, powdered beef bone, sodium chloride, alfalfa leaf, brewers' yeast, and reduced iron. (The oatmeal form of Pablum is called Pabena.)

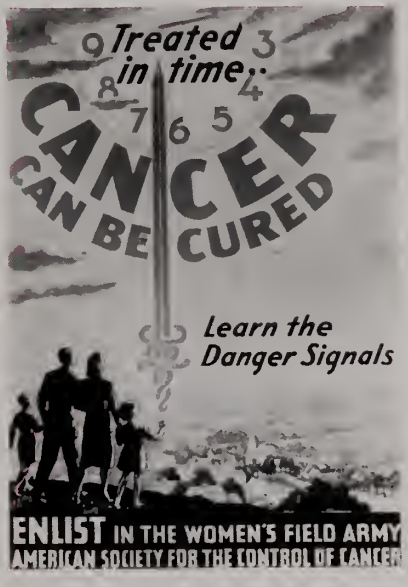
[1-18] Bibliography on request.

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Rhode Island MEDICAL JOURNAL

APRIL 1944



133rd Annual Meeting - - May 23-24-25

Volume XXVII, No. 4

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THE RHODE ISLAND MEDICAL SOCIETY
THE RHODE ISLAND DENTAL SOCIETY

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[1] Clement, F. W.; Elder, C. K.: Anesthesiology, 4:516, September, 1943.

[2] Forsee, J. H.; Shefts, L. M.; Burbonk, B.; Fitzpatrick, L. J.; Burford, T. H.: J. Lab. & Clin. Med., 28:418, January, 1943.

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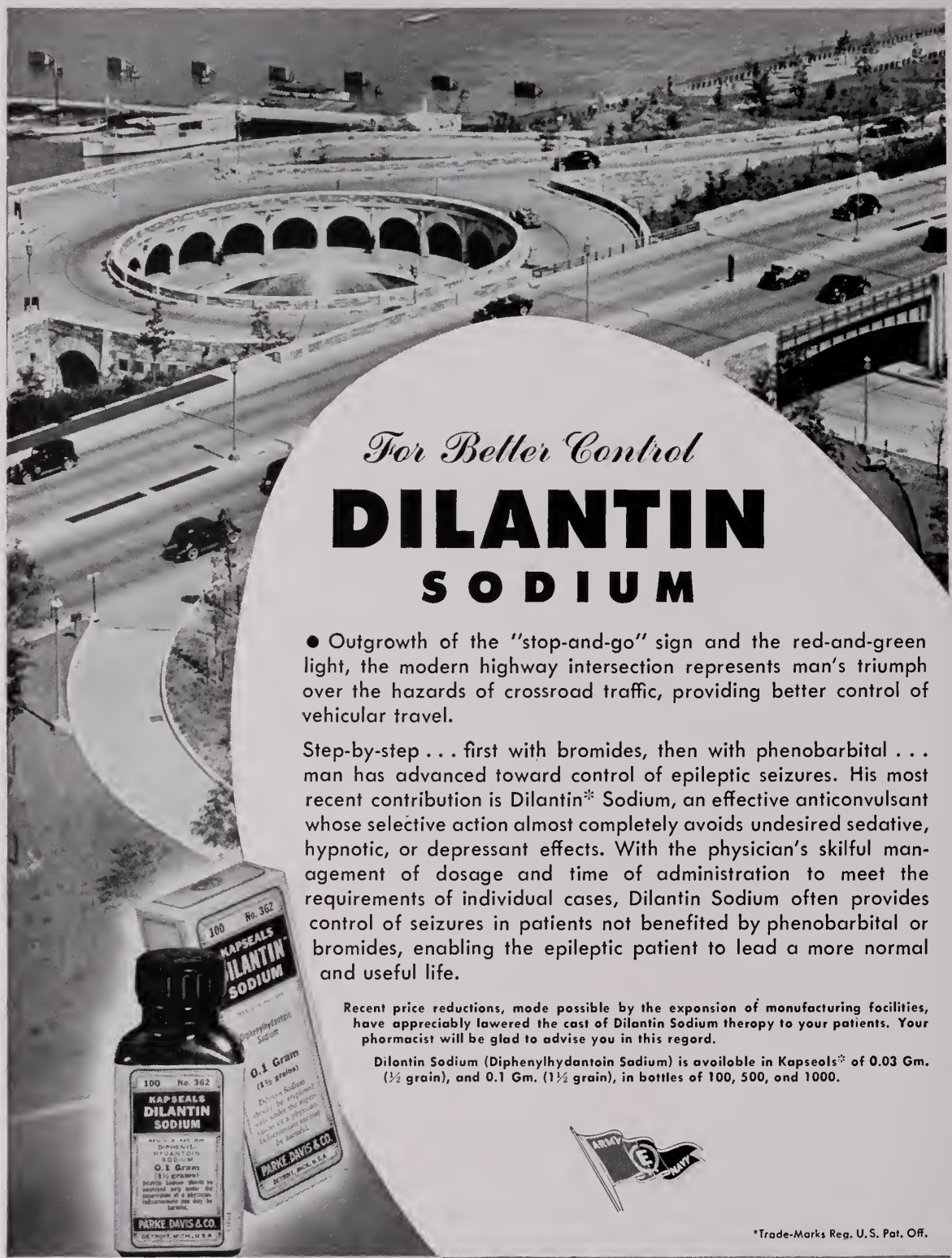
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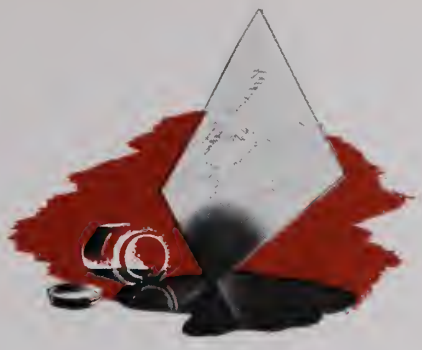
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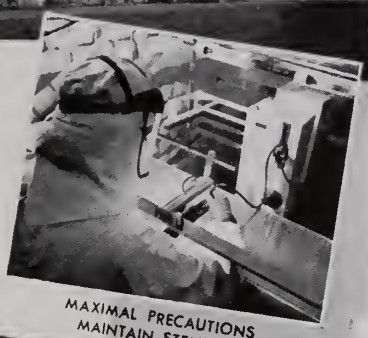
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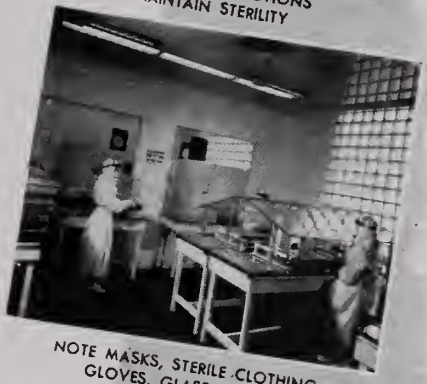
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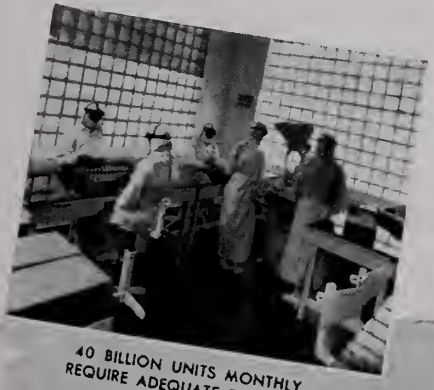
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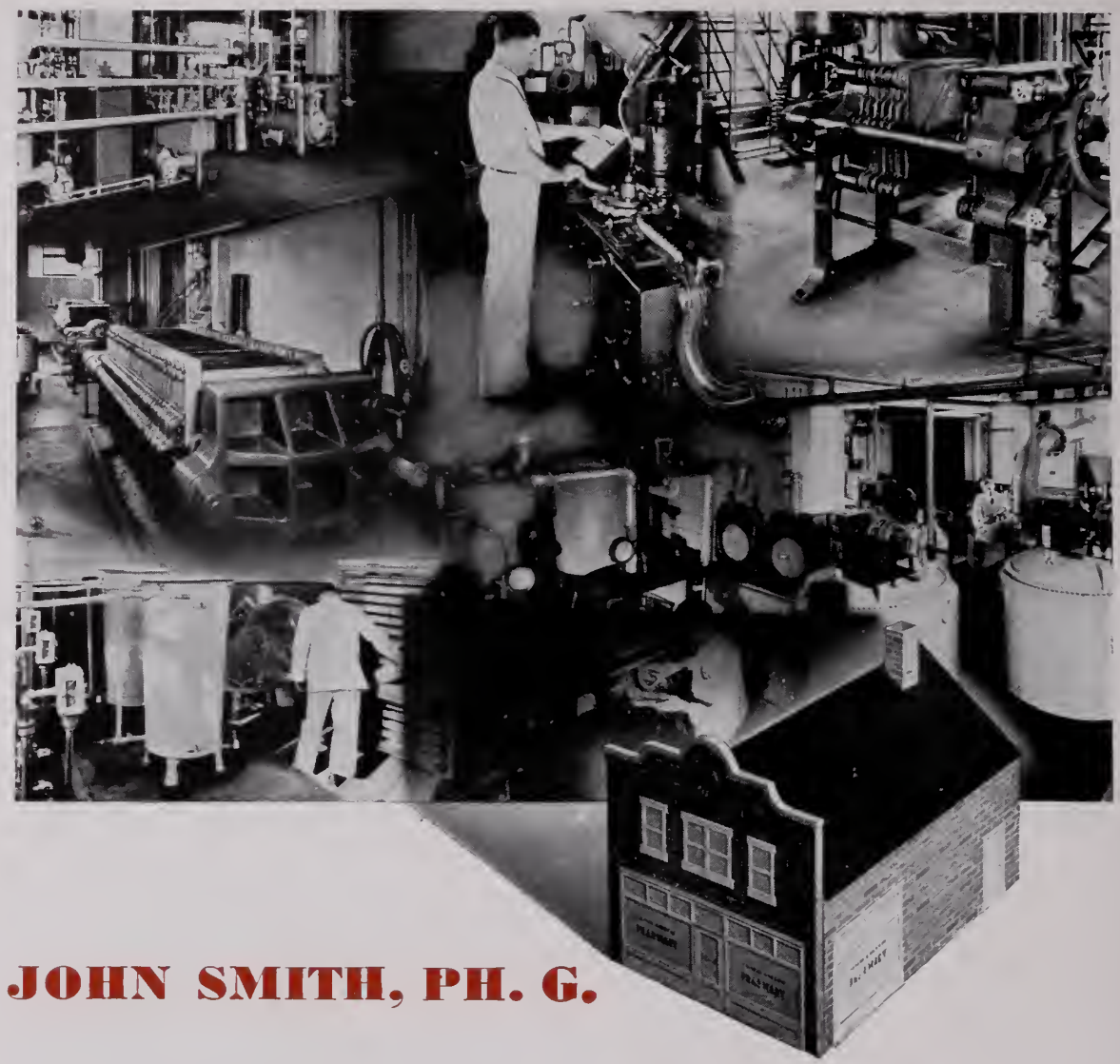
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVII APRIL, 1944 No. 4

OBSERVATION ON BERIBERI

MAJOR FRANK B. CUTTS, M. C.

The Author. *Major Frank B. Cutts, MC, 48th Evacuation Hospital; Assistant Visiting Physician, Rhode Island Hospital.*

DURING the eleven weeks from late July until the present (October 9, 1943) we have seen over 125 cases of beriberi. Our hospital admits American, Indian and Chinese patients, but all the instances of this disease were observed in the Chinese troops. We have learned that many mild cases were treated in the neighboring field hospitals or unit dispensaries, so that the actual incidence of beriberi was considerably greater than is reflected in our figures. When this disease first appeared, it was not immediately recognized, and several patients were admitted with such erroneous diagnoses as rheumatic fever, rheumatic heart disease, phlebitis and nephritis. It is the purpose of this report to briefly describe our experience in the hope that it may assist other medical officers, should they encounter a similar problem.

Clinical Picture

Although the symptoms and signs were somewhat variable, the clinical pattern was fairly constant.

HISTORY OF PRESENT ILLNESS:—Most of our patients had three major complaints:—1. Shortness of breath on slight exertion; 2. Swelling of the legs,—less often of the genitalia, hands and face as well; 3. Numbness of the legs, and muscle pain on walking. Less frequent complaints were palpitation, procordial pain, upper abdominal distension and numbness of the arms. Most patients had been ill 1 to 3 weeks before admission. In several instances such episodes as acute bronchitis, diarrhea or cholera vaccine injections had apparently precipitated their present illness.

PHYSICAL EXAMINATION: — Many of the patients were big rugged men, with no evidence of general malnutrition. During their illness they showed little or no fever. *TONGUE AND MOUTH*:—Usually normal. In a few instances the tongue was red and smooth, and occasionally there was some cracking and scaling at the corners of the mouth indicative of associated riboflavin deficiency. *NECK*:—In the sicker patients definite venous engorgement was present. Occasionally the neck veins showed marked pulsations suggesting tricuspid incompetence. *HEART*:—Almost always enlarged. With the patient sitting on the edge of the bed, the left border of cardiac dullness was quite consistently 1 to 3 cms. outside the nipple line. In a few instances a wave could be seen to pass from right to left across the precordium with each heart beat,—suggestive of right ventricular hyperactivity. The heart rhythm was regular except for rare extra-systoles, and the rate varied from 58 to 120 beats per minute. The first heart sound tended to be loud and booming, and often there was a triple (gallop) rhythm at the apex,—best heard with the patient lying on his left side. The second heart sound was usually distinctly louder to the left of the sternum than to the right (P2 A2). At times systolic murmurs of moderate intensity were heard at the apex and along the left sternal border. There was no diastolic murmurs. The blood pressure was not taken often enough to warrant any statement. *ABDOMEN*:—Negative except for an occasional palpable tender liver. One patient had temporary ascitis. *EXTREMITIES*:—Edema of the legs was almost constantly found, varying from 1+ to 3+ (on a 0 to 4+ scale) and at times involving the genitalia and extending up over the back. The hands and face were less often swollen and puffy. The calf muscles were in most instances normal altho occasionally the knee jerks, and more often the ankle jerks, were absent. The lower legs were very often quite insensitive to pin prick, and in some instances this anesthesia also involved the thighs and arms.

continued on next page

LABORATORY DATA:—We have little to offer here due to the lack of facilities for blood chemistry determinations, electrocradiograms, etc. However, the urines were normal, and there was rarely any significant anemia. Stool examinations showed findings parallel with the rest of our Chinese patients, ova of ascaris frequently and of hookworm occasionally.

TREATMENT:—This consisted of bed rest, the regular hospital diet, and Marmite (an autolysed yeast product rich in Vitamin B-1), 1 to 2 drams three times a day,—given in hot water or spread on a slice of bread or over rice. In a few of the sicker patients thiamine chloride, was given intravenously or subcutaneously in 5 to 20 mg. doses. In one critically ill patient, who survived, rapid digitalization, venesection and morphia subcutaneously were employed in addition to Vitamin B-1 administration.

COURSE IN HOSPITAL:—As a rule the the patients showed prompt improvement. Dyspnea at rest disappeared in 2 or 3 days. The heart rapidly shrank to normal size, the left border of dullness receding 1 to 3 cms. in the course of a week. This diminution in size was checked by serial chest X-ray plates in a few instances but was not done more often because of the shortage of film. Heart murmurs and other abnormal sounds disappeared in about a week. The edema of the legs and turgidity of the calf muscles were generally gone after 5 to 7 days of treatment. Numbness, insensitivity of pin prick and lost reflexes were more persistent and in some instances were but little improved after 6 weeks. In general, patients were sufficiently well to return to duty after 2 to 3 weeks. In a few instances Marmite was withheld. Improvement did occur but took approximately twice the time required by the Marmite treated patients, and complete relief from symptoms was usually not obtained until the Vitamin B concentrate was given.

There was one death. A 25 year old soldier came in complaining of marked shortness of breath for 3 days. On examination he was observed to be acutely dyspneic without definite orthopnea. The respiratory rate per minute was 35, and the temperture was 99. Definite engorgement of the neck veins was evident. The heart was 2+ enlarged, and auscultation revealed a loud gallop rhythm. The pulse could not be felt in either wrist, the apical heart rate being 96. The liver was just palpable and seemed tender, and there was slight peripheral edema. He remained pulseless and died 12 hours after admission. This patient was one of our earliest cases, and the cause of his illness was not recognized at entry so that he was not given any parenteral vitamin B-1. Autopsy showed generalized congestion and edema of the internal organs. The heart was dilated and distinctly flabby but otherwise entirely normal to gross examination. One ascaris worm was found wandering around in a dilated intrahepatic bile duct.

Etiology

Altho cases of this disease originated in many different Chinese Army units, it was soon noticed that fully a third of our beriberi patients were coming from one regiment. The cause for this was investigated by Lt. Kenneth M. Scott, M. C., and he uncovered the following information. This regiment had been requisitioning more rice than was required by its current needs and was storing the surplus. Finally in July, after the onset of wet weather, it was realized that the stored rice would probably spoil. Consequently, no new rice was drawn, and the unit began to consume the stored surplus. A sample of this rice was obtained and found to be grey, lustreless and devoid of any of the brown pericarp (rich in Vitamin B-1). Lt. Scott also found that in this regiment the soldiers with this disease tended to be the ones coming from parts of China where beriberi is endemic,—suggesting that their stored up reserves of Vitamin B-1 might well be low.

Since this rice has been discarded and new rice obtained, the incidence of beriberi in this unit is no greater than in other units in this area. At best, the diet of these Chinese soldiers is low in Vitamin B-1. They are given salt, cooking oil, polished rice, beef (fresh and tinned) and some vegetables, chiefly yams. Many are probably constantly on the verge of beriberi.

As a temporary expedient, "Atta", and undermilled whole wheat flour, has been added to the Chinese diet in the proportion of 4 oz. per man each day, during the past four weeks. Following, and probably because of, this change there has been a striking drop in the number of beriberi cases. The admissions with this disease for the week of October 3rd to 9th falling to one case from a previously weekly average of 17.

Recommendations

The obvious and simplest solution would be to provide rice that is entirely or in large part unpolished, thereby preserving the pericarp, rich in Vita-

continued on page 165

THE COMMON COLD

Reflectile Bodies as a Diagnostic Aid

HENRY L. C. WEYLER, M.D.

The Author. *Henry L. C. Weyler, M.D. Assistant Visiting Physician, and Associate, Cardiac Department, Rhode Island Hospital; Assistant Cardiologist, Providence Lying-In Hospital.*

THE common cold, grippe, influenza or virus infection became very prevalent in Rhode Island following August 1942 and extending through November 1943. There are certain outstanding features of this disease that will be discussed.

One of these relates to reflectile bodies that are found on the soft palate, uvula, pillars and posterior pharyngeal wall and occasionally on the mucous membrane of the cheeks. These are small superficial areas that are pin point to pin head in size (Figs. 1, 2). They reflect light and are glistening in appearance. The brighter the light the greater the reflection. They are often best seen when the light is projected at a slight angle. It is necessary to use good artificial light and to vary the angle in order to see these bodies on the different parts of the soft palate and uvula. Another method of examining the throat is to hold the light steady and at the same time tilt the patient's head back and forth. There may be a few reflectile bodies to several hundred present. Colored and black and white photographs show these bodies as bright pin point high lights that appear like wet spots. They cannot be brushed off with a swab. It is probably the wetness on these areas that is a factor in the light being reflected.

The reflectile bodies may last from a few days to months, becoming prominent and more numerous with each recurrence of the infection although the infection may take a new form every 4 to 8 weeks. The bodies vary in appearance during the course of the disease. In a typical case during the acute stage the soft palate becomes salmon colored as contrasted with the gray white color of the hard palate. The uvula becomes swollen and injected. The soft palate, uvula and pillars are streaked with injected small blood vessels. The posterior pharyngeal wall shows hyperplasia of lymphoid tissue. At the same time many (sometimes hundreds) of reflectile bodies may be seen over these areas. Occasionally one appears blistered on a red hemorrhagic base. These are most often seen at the base of the uvula.

The reflectile bodies are rarely found on the hard palate. They are frequently found in clusters at the junction of the hard and soft palates and at the base of the uvula. As the patient recovers from an attack of grippe or common cold the color of the soft palate changes to a light yellow, later to become normal. The injected vessels disappear gradually, leaving the pin point reflectile bodies. At times during recovery the pin point areas become larger and coalesce, causing a coarse granular appearance, at the same time losing their ability to reflect as much light. Usually there are some present when there is a recurrence or exacerbation of the disease in 4 to 6 weeks. At this time the acute picture in the throat becomes prominent again. In those cases that do not have a recurrence the reflectile bodies may remain for weeks or months after the original infection. These were so prevalent late in 1942 and in 1943 that at times most of the people examined showed them in one form or another.

Varied Symptom Complexes

About 1941, at a local medical meeting in Providence, attention was called to these bodies as a diagnostic sign in this type of virus infection. At that time the epidemic subsided fairly early so that one could follow the return to normal more readily than during the 1942 and 1943 period when one attack followed another at close intervals with varied symptom complexes. Although the exacerbations took on many different forms, many people had similar grouping of symptoms at the same time, as the disease seemed to progress from one stage to another. Of course there was a great deal of overlapping because some people became ill for the first time while others were having their 2nd, 3rd or 6th attack. There were at least six different attacks that were separate clinical entities.

continued on next page

The first phase started late in August 1942 and was very mild. Many people showed the acute virus throat described above. However, they had few or no complaints. When closely questioned they would admit becoming tired easily and lacking their usual "pep". Some said that they would have to rest for an hour or so late in the day before continuing with their duties. Others had some aching in the legs. Very few in the group had any increase in temperature. Recovery took place slowly and when they were feeling almost well again they had another attack similar to the first one, or of a different type. Usually the second attack came on in about 4 to 6 weeks after the onset of the original illness. During the first phase there were some cases of the so-called virus pneumonia. Vertigo was a frequent symptom in all phases of the disease.



FIG. 1. Reflectile bodies are seen near the junction of the soft and hard palates. Some are scattered over the soft palate. There is another group on the uvula. This picture was taken during the acute attack of common cold.

The second phase began with the complaint of a sore throat that was all out of proportion to the clinical findings. In addition they had the general complaints found in the mild first phase. They had very little glandular enlargment or tenderness at the angles of the jaw. The mild cases had very little increase in temperature.

The third phase occurred again 4 to 6 weeks later. This time, people had, in addition to the above symptoms, those associated with tracheitis, bronchitis, and in some cases the so-called virus pneumonia. One case of virus pneumonia came to autopsy 12 days after the onset of the illness and presented findings similar to those described in 1918 during the influenza epidemic. The cases in the third group frequently had a rise in temperature. Some remained high for several days and then became subnormal for several more. Others had a late afternoon and evening rise. Attacks of sweating continued long after the temperatures returned to normal. Occasionally one had a low grade temperature late in the day which lasted for weeks.

The fourth phase was associated with sneezing, a watery nasal discharge and many of the symptoms described previously. In addition many complained of stiffness of the neck and vertigo.

The fifth phase presented itself as usually described as a severe grippe with generalized aches and pains and an increase in temperature above normal. Some had recurrence of tracheitis, bronchitis, and the so-called virus pneumonia.

The sixth phase was characterized by neuralgic pains associated with the head for the most part. Some had tri-facial neuralgia and pain back of the head. Vertigo again was a common symptom.

Clinical Observations

These different types of common cold occurred in recurrent form at fairly definite intervals and in a general way in sequence. It is not to be construed from this that all people had the six phases. Almost all started with a mild phase and then developed any one of the others later on without having gone through the entire series as depicted. However, there were enough people having any one of the same phases at the same time to suggest definite clinical entities. No attempt is being made to go into the other details of the disease which are so well known. The main purpose in presenting the various types of the epidemic is to point out that the throat findings are always typical with each different attack. Moreover, it suggests that the recurrences may be exacerbations of persisting infection.

There was a group who had an increase in temperature with its attending symptoms. They had few symptoms, however, associated with the upper respiratory tract. Moreover, they did not have the typical throat findings, namely: the salmon colored soft palate, marked injection of the vessels, or definite reflectile bodies. Whether this type is a different entity or a special group of people reacting in a different way is not known.

During the 1942-43 interval there was another group who presented gastrointestinal symptoms. They had nausea, vomiting and diarrhea. They

had considerable distention of the large intestine which recurred one or more times after about a week to 10 days. They also did not have an upper respiratory infection nor did they have the typical throat findings. In a number of these cases organisms belonging to the paracolon group were recovered from the stools. I am sure many of these cases had been diagnosed as intestinal influenza or grippe.



FIG. 2. Taken on same patient as shown in Fig. 1, two months later. He had had an exacerbation after being ill for several weeks. The reflectile bodies can be seen scattered all over the soft palate.

There were also many other types of virus infection seen during this same period that did not show reflectile bodies. Some of these were mumps, herpes, German measles and poliomyelitis. Moreover, the reflectile bodies were not seen in other conditions such as pneumococcus pneumonia, meningococcus meningitis, lymphatic and myelogenous leukemia. It is also true that these same conditions, when associated with the common cold, showed the bodies. One would be almost tempted to say that the absence of these reflectile bodies means the abscence of common cold. On the other hand the presence of these bodies may mean past or present common cold infection depending on the color of the soft palate and injection of the vessels. Their presence does not exclude other diseases being present at the same time.

Although the pathology of these raised areas has not been worked out we do know that there are a great many mucous glands in the region described. They are just under the surface of the mucous membrane of the soft palate. Under certain conditions these glands are filled more than usual. It is possible that these filled glands cause the mucus membrane to protrude, producing raised areas that reflect light. An excess production of mucus was a frequent finding in the common cold seen in Rhode Island during 1942-43. It is possible that other conditions such as infection with Friedlaender's bacillus would also show reflectile bodies. Although it is true that this type of speculation regarding the pathology does not prove anything, it is hoped that it may stimulate interest in others.

Summary

Small pin point to pin head areas are described on the uvula, soft palate, posterior pharyngeal wall and pillars. Because these areas reflect light they are being called reflectile bodies. They are found in people having common cold, grippe, influenza or the so-called virus pneumonia. During the acute stage of the infection the soft palate is salmon colored, later changing to a light yellow and then back to normal. There is marked injection of the small vessels in these same areas. The reflectile bodies remain from days to months after the acute phase has disappeared.

OBSERVATION ON BERIBERI

continued from page 162

min B-1. The Theater Food and Nutrition Officer, Capt. M. J. Babcock, who recently investigated the matter has recommended the following ration:

1½ lbs. unpolished rice, 8 ozs. beef, 8 ozs. vegetables (50% green vegetables), 2 ozs. dried beans, 2 ozs. peanuts, 4 ozs. atta flour and ⅝ ozs. cooking oil. This would supply an estimated daily intake of about 3.0 mg. of thiamine (Vitamin B-1) which would be ample. These recommendations have been made to the proper authorities.

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MATERNAL HEALTH

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DISCUSSION . . . No. 3675 — 1941

This patient had adequate antepartum and postpartum care. Pregnant women with rheumatic hearts which have never been decompensated usually do very well if properly managed. The cardinal points in the treatment are control of weight and limitation of their activities with complete bed rest on the slightest indication of impending decompensation. Whether pregnancy necessarily shortens the life of patients suffering from heart disease is a disputed question. This patient's heart was so seriously damaged that she would have died had she not been pregnant. It was therefore classified as a non-obstetrical death.

DISCUSSION . . . No. 37706 — 1941

This patient made her first visit to the clinic in her eighth month. Despite years of effort to educate patients to place themselves under a doctor's care in the early weeks of pregnancy, patients, particularly clinic patients, still fail to heed our oft repeated warnings. In spite of a blood pressure of 150/100 and albumen and casts in the urine, she reported for examination only four times in six weeks. Such a patient should report at intervals of not less than one week. The committee has no way of knowing how faithfully she followed instructions and whether hospital treatment was advised. If it was not it should have been. The diagnosis of essential hypertension is open to question. Certainly albumen and casts in the urine are clear indications of kidney damage due either to hypertension of long standing, chronic nephritis or the toxemia of pregnancy perhaps superimposed on a hypertension or chronic nephritis. To arrive at a satisfactory diagnosis it would be necessary to have a reliable history antedating her pregnancy and a follow up for some months after her delivery. Neither of these are available. But an exact diagnosis as a guide to treatment is not necessary in these cases. Hypertension with albumen and casts in the urine is indication enough for prompt and vigorous treatment. This, the patient in this case did not get. The prognosis of "guardedly favorable" was doubtless justified for many such cases go to term without serious trouble. On the other hand again and again we get case reports similar to this—moderate hypertension, with or without albumen and casts in the urine, and no marked change in the signs or symptoms for some weeks and then suddenly a sharp rise in blood pressure, scanty urine or complete suppression, coma, perhaps convulsions and death. Again we must repeat that any pregnant woman with a diastolic blood pressure of 100 or over is skirting the brink of a precipice.

Report on E M I C Program

Babies and their mothers cared for under the Emergency Maternity and Infant Care program totalled nearly 200,000 by February 1, according to a statement made by Katherine F. Lenroot, chief of the Children's Bureau. Some 30,000 new applications were approved in January.

In an OWI release relative to the progress of the program Miss Lenroot was reported as expressing the hope that through this first contact with State health services many mothers will become interested in the work being done in well-baby clinics and child-health conferences in the States.

The total number of maternity and pediatric cases for which any service has been authorized from the beginning of the program in April, 1943, through January 31, 1944, for the New England States is as follows:

	In December	In January	Total as of January 31	Date of Approval of State Plan
R. I.	134	243	913	Apr. 27, '43
Conn.	325	368	2,735	May 14, '43
Mass.	1,298	1,418	6,668	Aug. 30, '43
Me.	138	252	1,560	May 4, '43
N. H.	141	127	902	June 8, '43
Vt.	55	130	834	Apr. 16, '43

A 7-member subcommittee of the House Committee on Appropriations is now conducting hearings preparatory to formulating the Labor Department Federal Security Appropriation Bill for 1945. Since any additional regular appropriations for the continuation of the obstetric-pediatric program during the fiscal year beginning next July 1 would be included in this bill, the special committee appointed by the Council of the Rhode Island Medical Society to report on this program (see Journal of December, 1943) has made known to the Congressional committee the objections of the Society to the present administration of the plan.

The RHODE ISLAND MEDICAL JOURNAL

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MORE THAN A TRADITION

The 133rd annual meeting of the Society represents more than the mere continuance of a tradition. Its true significance can best be measured by an evaluation of the scientific presentations that have been offered through the years as the medical profession of Rhode Island has kept pace with the advances in medical research.

When Dr. Amos Throop, prominent physician, member of the General Assembly and president of the Exchange bank, was elected first president of the Society in 1812 he headed a group of but forty-nine doctors. Of these, according to historians, not more than nine "had their M.D.'s, but the majority of them were men of sterling ability and wide experience."

To bleed or not to bleed was the medical controversy of the early days, and it is indeed a long step from the procedure of blood-letting followed by tartar-emetic and purges, with no nourishment nor stimulants whatever, for pneumonia treatments, to the modern methods highlighted by the use of sulfa drugs, oxygen therapy, and hospitalization.

The stethoscope and clinical thermometer were yet to come into use and the field of surgery and obstetrics was yet to be completely altered by the discovery of anesthesia. Yet the Society met regularly, in alternate years at Newport and Providence, for the reading of lengthy papers, for the adoption of motions and resolutions, and for discussions of medical matters which would sound odd today.

As medical science marched at accelerated pace the Society responded with scientific papers and continued frank discussions of them at the annual meetings. Dr. Caswell's paper on "Lister's Method of Antiseptic Surgery" in 1878, the first mention of this subject before the Society, led to many arguments pro and con. The outstanding monographs by Dr. Robert F. Noyes in 1882 on "Perityphlitis", and by Dr. Reginald Fitz on "Appendicitis" in 1886 played the major role in establishing the identity and pathology of the disease and opened the way for one of the greatest advances in surgery.

One hundred and thirty two years ago, as the Society organized for its first scientific assembly, nations of the world were embroiled in conflicts and Napoleon was experiencing his catastrophic retreat from Moscow. Again the nations are in martial conflict, and another would-be conqueror marches ingloriously out of Russia. Again the medical profession of Rhode Island stages its annual assembly in a world at war, to plan and prepare for greater expansion of the science of medicine in a happier and healthier tomorrow.

ARIZONA MEDICINE

These are parlous times for periodicals. You probably have noticed that your favorite magazine does not come to you far ahead of its printed date as formerly. And medical journals find that technical articles are getting decidedly more scarce.

Under these circumstances, the Arizona Medical Society has brought out Volume 1 of Arizona Medicine. South Western Medicine, published by two state and two local societies has been discontinued for the duration.

With the enthusiasm and optimism characteristic of our western people, this new venture is starting bravely forth to take its place.

Little Rhode Island, way to the East, small and congested, rather the antithesis of Arizona, has a journal that in these difficult times has, we believe, taken on a new base of life. With sympathetic fellow feeling, we congratulate Arizona Medicine and wish it success.

MORE CANCER EDUCATION

It is probably too soon to estimate the value of Lay Education in our fight against Cancer. True this Education has been going on for some years now, but never before has it reached the scope or intensity attained since the American Society for the Control of Cancer organized its Women's Field Army eight years ago.

The growth of the Army has been truly phenomenal. There are branches in practically every State of the Union and these branches are active working bodies. The women are deeply interested and eager to learn what they can about Cancer and particularly of its early signs and symptoms.

To gratify this laudable thirst for a greater knowledge of the problem the parent Society has encouraged the holding of what are called, "State Training Schools".

Rhode Island's first such Training School was held Thursday, March 2nd, in the auditorium of Peter's House at Rhode Island Hospital. Women came from all parts of the State, nearly 150 strong, and stayed for the morning session and the afternoon session, with luncheon in between in a dining room of the Hospital.

The morning session was devoted to seven very excellent talks on Cancer by various doctors. In the afternoon organization of the Women's Field Army was discussed and there were papers on the practical work carried on among Cancer sufferers. A dinner meeting was held in the evening at which Dr. C. C. Little, Managing Director of the American Society for the Control of Cancer, spoke.

The future of any great movement depends very largely on sustained interest. This matter of educating the public about Cancer has reached such proportions that it can very rightly be called "A Great Movement".

It is gratifying to find that our Medical Men are willing to give freely of their time and energy in an effort to sustain interest long enough to justify the high hopes of the many who feel that a better understanding of Cancer among our people will bring lessened suffering and a reduced mortality.

BUTLER HOSPITAL'S CENTENNIAL

When Richard Brown built Rhode Island's first brick structure in 1731 along the shores of the Blackstone little did he dream that it would one day be the main house for one of America's outstanding private hospitals. Grotto Farm, a tract of land about 14 acres with Richard Brown's house thereon, was purchased in 1844 as a site for Butler Hospital, the first mental institution and the oldest hospital of any kind in Rhode Island.

In this, its Centennial Year, Butler Hospital may proudly review its one hundred years of accomplishment which have made it an institution of national preeminence, and which have added immeasurably to the health care of the people of Rhode Island. Physically the hospital has enjoyed a sizable expansion. It now owns 138 acres of land to give it one of the finest hospital surroundings we have ever seen. Its floor area has expanded four-fold, and its building and equipment valuation has increased more than twenty times its original assessment.

But it is not its physical structure that has made Butler Hospital a great institution. Rather its significant contributions to the methods for the care and treament of nervous and mental illness have made it known the length of the land. From its beginning under the leadership of Dr. Isaac Ray who was the first to eliminate the narrow, cramped and prisonlike aspect of the average institution of that era, through years of illustrious guidance by Drs. Sawyer, Goldsmith, Gorton, Blumer, and since 1922 by Dr. Ruggles, Butler Hospital has exerted a profound leadership in its field.

In progressive and modern psychiatric methods and treatments the Hospital now occupies a unique position among American hospitals. It is singularly fitting, therefore, that the first celebration of its

anniversary year, to be held on May 10, should be a scientific program with presentations by some of the country's outstanding psychiatrists.

DENTAL REHABILITATION

The major cause of rejection cited in analyses of reports of physical examinations of Selective Service registrants was that of dental defects. Yet this situation certainly cannot be blamed upon the dental profession of America any more than other physical defects can be laid to any shortcomings in the service of the medical profession.

Man has always been prone to await for physical pain as a warning of some ailment, but not always is there pain to indicate a weakening of the physical structure. Even when pain exists too often it indicates a neglect that defies the ability of any physician to remedy the damage already done. The problem is plainly one of health education.

An outstanding approach to dental education and dental rehabilitation is being carried on by the little publicized dental corps of the Army and Navy. The lowering of requirements to meet the demands of the Services has added to the work of these Corps, but their achievements in caring for the men will certainly have a tremendous effect on the entire profession in the years of peace ahead.

According to a recent report approximately fourteen thousand men of the dental corps have furnished more than a million new dentures, filled more than thirty one million teeth, provided more than fifty thousand bridges, repaired approximately two hundred and twenty thousand dentures, and have given more than three and a quarter million prophylactic and pyorrhea treatments.

This imposing record, and the continuance of the care of the teeth of every man in service, should advance dental education far more than any peacetime program could do in years of effort. Certainly the majority of our military forces are going to be more conscious of the value of proper and adequate dental care when they return to civil pursuits. Therein lies a vital issue for the dental profession of this country—the necessity of forging strong peacetime educational and professional programs in order that the great gains now being made may not be lost due to neglect or indifference on the part of either the doctor or the patient.

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SOME IDEALS AND INFLUENCES IN THE FORWARD MARCH OF DENTISTRY

ALBERT L. MIDGLEY, D.M.D., SC.D.

The Author. *Albert L. Midgley, D.M.D., Sc.D., Chairman, Committee on Dental Research of American College of Dentists; Contributing Editor, Journal of American College of Dentists.*

For a better understanding of what is to follow, it seems appropriate to have something to say at the outset about the acceptance of the focal infection theory, the Dental Educational Council of America, and the Study and Survey of Dental Education by Dr. William J. Gies under the auspices of the Carnegie Foundation for the Advancement of Teaching. These three were the basic moral forces chiefly responsible for the irresistible forward surge which impelled dentistry to elevate its professional standards both in education and in practice.

A new day dawned for dentistry in 1910 with the advent of the focal infection theory and its prompt acceptance by men of science. It brought to the dental profession a message of hope and courage and a vision of real values in education and in practice, together with new obligations and concurrent opportunities. In that year it was publicly reasserted—and this time with dramatic effect—that diseases of the mouth and of the teeth may be directly related to general health. The implications of this scientific discovery were of immense importance to dentistry and to the public welfare, for they put an end to the isolation of dentistry and demanded its full recognition as an indispensable division of health service. Thus it was that the focal infection theory transformed the more or less unacceptable status of dentistry as a health-service profession of those days to its present condition of ever-growing importance and usefulness in its educational, professional and civic activities and relationships. Among other things, the newly accepted theory directed attention sharply to the necessity of a more effective medico-dental relationship in education and in practice, impelling dentists and physicians to pool their interests and resources in the solution of problems of common interest and concern. It focused sharply upon the need of better teaching and research in the attainment of this indispensable relationship. Beyond doubt, it was at least the predisposing influence which has promoted the ceaseless growth of dentistry in public respect and appreciation since that time.

Acceptance of the focal infection theory indicated plainly that the dental profession should no longer accept vocational education alone as the basis of entrance, but should rather require a preprofessional collegiate education, if dentistry was to attain a position of excellence in health-service education and reach a status of scholastic equality with medicine. This fact, together with the ideal of ever-broadening opportunity for professional service, has suggested with increasing urgency our fellowship and cooperation with medicine. The focal infection theory is itself the focal point of professional collaboration and sharing of responsibility for the nation's health.

Aims of Dental Educational Council

It is of more than passing interest to note that coincidentally with the announcement of the focal infection theory, the Dental Educational Council of America was created. The aims and purposes of this Council on Education in dentistry, and its policies and program, are similar in many ways to those

of the Council on Medical Education of the American Medical Association. It aimed to elevate the standards of dental education through the adoption of Minimum Requirements for Class A Dental Schools, which included items pertaining to administrative policy, minimum entrance requirements, entrance to advanced standing, faculty and teaching staff, equipment and teaching facilities, course of study, rules of attendance, promotion and graduation, state board record, and a definition of Class A, Class B, and Unclassified Schools.

The following explanation of "definition of Class A, Class B and Unclassified Schools" will give the reader a better conception of the quality of dentistry's effort to elevate its status in the education and training of dentists.

1. A school shall be considered fully acceptable and designated as Class A if it fairly meets and maintains the requirements as set forth by the Council in its Minimum Requirements for Class A Dental Schools.

2. A school which in certain particulars does not meet all of the requirements of the Council's Minimum Requirements, but which, in the judgment of the Council, will be able to meet them within a reasonable time, and which meanwhile is making full utilization of its facilities and is devoting all of its income to the promotion of teaching and advancement of dental education, shall be considered as worthy of assistance and designated as Class B.

3. A school which (1) cannot meet the Council's Minimum Requirements without extensive improvement and complete reorganization, or (2) which is conducted for profit to individuals or to a corporation, or (3) which does not meet any other minimum requirements that are regarded as essential for an acceptable school, is not acceptable and shall be designated as Unclassified.

When it shall appear from the official records to the secretary of the Council that any Class A or Class B school accepts students on lower standards of entrance requirements than those set forth in the Council's Minimum Requirements, the classification of such a school shall be immediately withdrawn and the school listed and published as Unclassified.

Evidence that the classification of the dental schools was a potent influence in the promotion of dental education is quite convincing, since it resulted in the prompt disappearance of most of the proprietary schools, and the transition of many of them into universities. This forward step was influential in attracting the attention of the authorities of universities and medical schools not only to dentistry's educational sincerity but also to its conviction that professional education cannot be conducted for profit.

The purpose of the Dental Educational Council in raising the entrance requirements and extending the curriculum of American dental schools was not merely to round out the undergraduate course and establish a formal scholastic equality with medical schools, but to prepare the way for dentistry to accept and perform its appropriate part in advancing the frontiers of knowledge. Under the conditions which had previously obtained, there was great disparity between dental schools, and the deficiencies of some were undoubtedly visited upon the dental profession as a whole.

Carnegie Foundation Study

In 1918 the initial classification of schools was issued by the Council, with Class A, Class B and Class C designations. It was a new challenge, in floodlight form, forcibly emphasizing increased responsibility and attendant opportunity. There can be little doubt that this courageous action on the part of the Dental Educational Council was the predisposing influence in the decision of the Carnegie Foundation for the Advancement of Teaching to undertake its study and survey of dental education.

In 1926 came the public and authoritative pronouncement of the Foundation, with its thorough and impartial report on Dental Education in the United States and Canada, giving an irresistible impetus to the forward movement by defining again the position of dentistry in health service, and at the same time submitting to the public exhaustive information and fearless comment upon conditions in each of the dental schools.

What we of the new day may expect from dentistry, and what we should do for dentistry, may still be gathered from that masterly study set forth by Dr. William J. Gies under the auspices of the Carnegie Foundation for the Advancement of Teaching: namely, (1) the conception that dentistry is primarily a health service, (2) the conviction that dentistry should be made fully equivalent to an oral specialty of medical practice in service to the patient, and (3) that dentistry should remain and grow as an independent profession to be maintained on the same intellectual level as other learned professions and closely correlated with medicine in education, research and practice.

Experiences and attainments over the years have shown us that the manner in which dental students should be educated for their profession depends, in

continued on page 173



Doctor—has this ever happened to YOU?

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FORWARD MARCH OF DENTISTRY
continued from page 171

the last analysis, upon what is understood to be the function of dentistry in its most comprehensive sense. At the close of a century of organized existence, with more than one hundred years of professional consciousness at our back, we are in a position to trace very accurately the development of our conception of what dentistry should be and what a dental education should include. For the first seventy years, the record was one of conscious, determined effort for improvement in all phases of endeavor, characterized by experiment and success in the perfecting of techniques, instruments, and restorative substances, and by the gradual attainment of extraordinary manual skill and precision in the most delicate operations. During the past thirty years, stimulated by the knowledge that diseases of the mouth and teeth are inseparably connected with general health, dentistry has been raised to the rank and responsibility of a learned profession, including in its educational requirements not only the biological sciences but also a sufficient amount of liberal arts to give the dental graduate a cultural equality with the medical graduate. This action was a direct and logical acknowledgment of the great responsibilities and permanent obligations of dentistry to which all trends in dental education should naturally conform. Every thoughtful dentist will affirm that the principles and influences which control the education and training of the dental undergraduate must, now and hereafter, be so organized and applied that he acquires an ever-broadening vision of professional responsibility and an ever deepening mental culture, inseparably linked with skill and understanding in essential manipulative procedures.

In an address to the dental students at Harvard, in 1924, President Emeritus Charles W. Eliot, one of America's most eminent sponsors of dental education, said: "I want to congratulate you on the greatly improved standing of the dental profession among the professions. That is one of the most striking changes in public opinion that I have witnessed during my seventy years of observation of educational progress . . . I do not think I have seen during my seventy years of observation of the professions and the means of training them any change so great as that which has taken place in regard to the dental profession, and to the means of training dentists . . . Look forward, therefore, to the future of your profession with great hope."

While much progress had been made between 1918 and 1924, it was plainly the sowing season, for the impressive forward surge of the present epoch in dental education began in 1926, upon the issuance of the report of the Carnegie Foundation for the Advancement of Teaching, and has continued with accelerating tempo ever since. If President Eliot were alive now, it would be interesting to learn what he might have to say today about the improved standing of dentistry among the professions.

The enforcement of an entrance standard of at least two years of preprofessional collegiate education has coincided with the beginnings of a more cordial and effective cooperation with medicine in teaching, research, and all other activities directly or indirectly connected with health service. There again dental leadership aims to hold dentistry abreast of every advance in culture and science, and thus to maintain an equal level with all other members of the university family. That our dental schools are keenly alert to their responsibilities in meeting present-day and future requirements of practice is emphasized by the recent conclusion of an exhaustive study and survey of the dental curriculum.

Social and Economic Phases

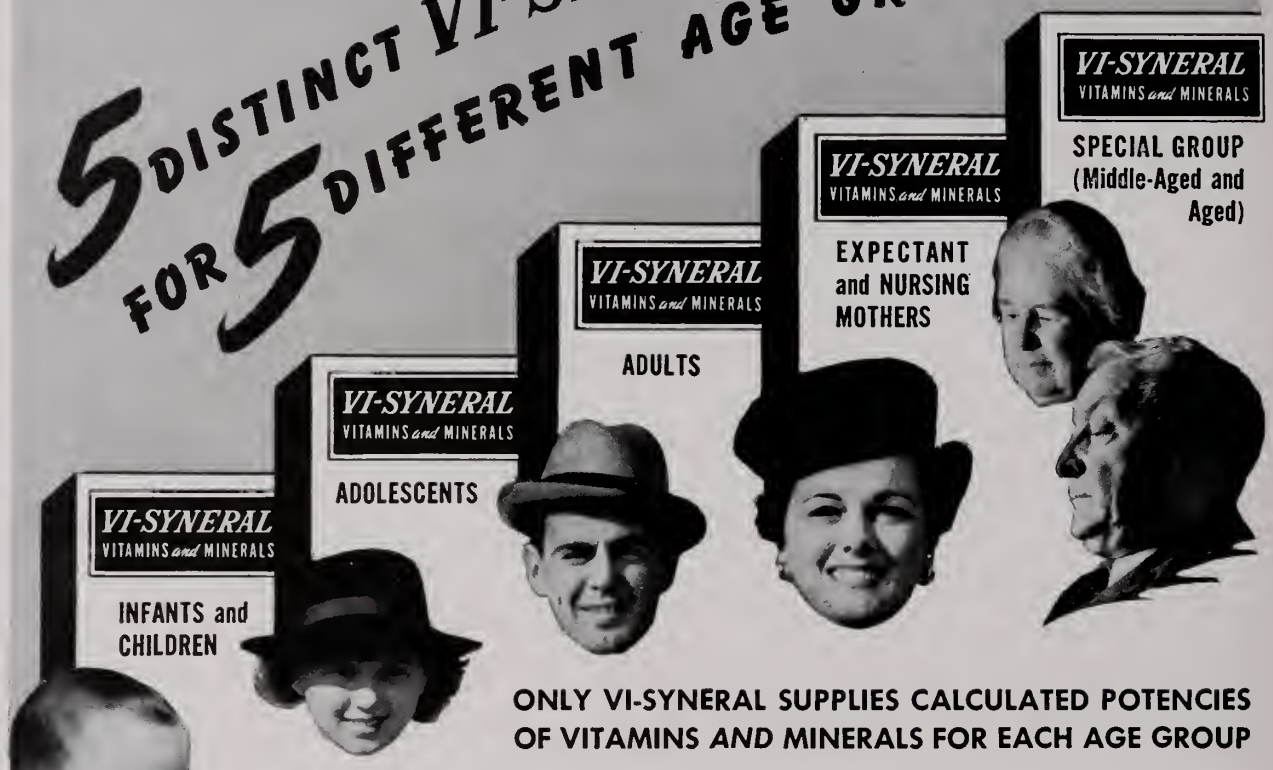
The social and economic phases of practice have been given due attention, one valuable result of which was the presentation of a comprehensive study of European Health-Service Insurance. The conclusions of this study brought, not only to dentistry but to medicine as well, authoritative information that has been found very useful in the development of programs of state medicine.

The fully developed conception of dentistry as a learned and liberal profession is maturing solely under university ideals, auspices and control, with due regard for a high quality of preprofessional collegiate training and definite consideration of the values of research in developing capable and inspiring teachers of dentistry—teachers who have an accurate knowledge and understanding of the basic sciences, and who are competent to make practical and detailed application of this knowledge and understanding.

Meantime, the subject of dental literature has not been ignored. Mindful of the value and influence of professional publications, the profession instituted a rigorous study and survey of dental journalism. Today, the tradehouse type of magazine is practically extinct, and members of the American Association of Dental Editors are producing responsible and dignified publications which meet the rigid ethical standards of high-grade professional journalism.

continued on page 193

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CANCER AND WORKMEN'S COMPENSATION ACTS

Wisconsin passed the first state compensation law on May 3, 1911 to become effective on September 1st of that year. Other states followed suit until now all the states, with one exception have laws regarding workmen's compensation. They are in a confused state however. They vary in their style, waiting period, form of disability, completeness of benefits and coverage for occupational diseases and injuries.

Prior to the enactment of such laws injured workers had to prove that the injuries were due to the negligence of the employer in order to collect. Even then it was necessary to rule out contributory negligence of the employee, the negligence of a fellow worker, or the employee's willingness to assume the risk when he accepted employment. Under Workmen's Compensation Act laws the three common law defenses were no longer available to the employer. The burden of economic loss and waste due to personal injury has been shifted from employee to industry and made a part of the ultimate cost to the consumer. The liability of the employer without proof of fault is the essential principle on which Workmen's Compensation Acts are based.

In recent years occupational diseases have been included. An occupational disease is an affliction due to a specific industrial health hazard. Some claim it must arise "out of, or in the course of" such as lead, arsenic, mercury or silicon poisoning. Others claim "Any disease contracted by a worker which arises out of—or out of an incident of employment and yet not necessarily characteristic of employment" is occupational, such as tuberculosis or malaria.

In Rhode Island occupational disease means disease which is due to causes and conditions which are characteristic of and peculiar to a particular trade, occupation, process or employment.

The February, 1944, issue of the publication of the American Society for the Control of Cancer, Inc., there is an interesting article by I. H. Rubenstein, of the Chicago Bar, on the subject of "Cancer as an Accidental Injury". Rubenstein reviews twenty-one compensation cases involving cancer. He states that these cases reveal that they may be divided legally into two types. In the first type of case it is claimed that the injury CAUSED the cancer which brought about the resultant disability or death of the injured employee while in the second type of case it is claimed that the injury AGGRAVATED AND ACCELERATED THE PRE-EXISTING CANCER.

Cases of the first type, however, are manifestly limited to those where trauma can conceivably be assumed to have caused cancer. Admittedly medical science does not know the cause of cancer. However, cases which have been found to reveal certain cancers which because of their peculiar type and particular location in the body, could not be caused or aggravated or accelerated by an injury, blow, strain or cut, were refused disability even though trauma was present.

In many other instances, however, where there seemed to be a reasonable assumption that the violence of the trauma in a previously normal individual produced an injury which eventually developed cancer or so severely traumatized a pre-existing

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Annual Meeting

The first annual meeting of the Rhode Island Society of Industrial Physicians and Surgeons will be held on Tuesday, MAY 23, at the Rhode Island Medical Library, one day previous to the annual meeting of the State medical society.

A program of interesting speakers has been arranged, and some interesting exhibits will be shown also. Complete details of the program will be published in the next issue of the *Journal*, and will also be sent in advance to all members of the Society. All physicians and nurses, as well as industrialists, personnel managers, and business men, interested in industrial health problems will be extended an invitation to attend the meeting.

Check the date on your calendar now—MAY 23!

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Pessaries (Vaginal Suppositories) 0.1 mg., and 0.5 mg., boxes of 12 and 50.

A preparation of natural estrogens, Amniotin is also available. It is obtained from urine of pregnant mares—is a highly concentrated, non-crystalline preparation of estrone together with small varying amounts of other estrogenic ketones. It is supplied in corn oil solution for intramuscular use and in capsules for oral administration. Also in pessaries.

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DISTRICT SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The annual meeting of the Pawtucket Medical Association was held at Butler's Diner in Pawtucket on Thursday, March 16, 1944. A steak dinner was served. The meeting was called to order by the President, Dr. Joseph Doll. The annual financial report was presented by the Treasurer, Dr. A. A. Bertini. Election of officers was then held and the following slate was installed for the ensuing year:

President—Edward Trainor, M.D.
Vice President—Orland F. Smith, M.D.
Secretary—William N. Kalcounos, M.D.
Treasurer—Laurence A. Senseman, M.D.
Standing Committee—
Armand A. Bertini, M.D.
Councillor—James L. Wheaton, M.D.
Delegates—Walter J. Dufresne, M.D.
J. Lincoln Turner, M.D.
Earl J. Mara, M.D.
Stanley Sprague, M.D.

Dr. Doll then called upon Dr. John F. Kenney to act as toastmaster. Dr. Kenney then proposed that the secretary communicate with all society members now in the armed forces in regard to the new officers and to give a general report of the annual meeting.

He then called upon Dr. T. W. McDonald, President of the Pawtucket Dental Society who thanked the physicians for their cooperation with the dentists and for including them in the newly organized Journal.

Dr. Kenney asked Dr. Wheaton to address the society and Dr. Wheaton extended greetings from the State Society.

Dr. Charles L. Farrell was then called upon to give a brief resume of his work in connection with the Industrial Physicians Society.

Dr. Orland Smith was asked to present a report on the blood bank; he told of the success of the new program in which donors are taken from the industrial plants, their blood being used to replenish the hospital supply of whole blood and plasma, and they in turn are given credit with the hospital in the event that they or members of their families should need transfusions.

Dr. Earl Kelly proposed that the secretary send a letter to Dr. Stanley Sprague thanking him for his excellent work in connection with the weekly radio programs, and that the society extend a rising vote of thanks to the out-going President, Dr. Joseph Doll, and to the out-going Treasurer, Dr. Armand Bertini.

Respectfully submitted,
MARY-ELAINE J. ROHR, M.D.

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held on Monday, March 6, 1944 at the Medical Library. Dr. Albert H. Jackvony, President, presided.

continued on page 179



LIEUT. CHARLES S. DOTTERER, MC, USNR
President of Newport County Medical Society — 1944

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DISTRICT SOCIETY MEETINGS

continued from page 177

The minutes of the previous meeting were read by the Secretary and were approved and placed on file.

The Secretary reported that the Executive Committee recommended for election to active membership Dr. Anthony C. Verrone who is now serving with the armed forces. Dr. Verrone was unanimously elected to active membership.

The President announced that the plan whereby four exhibitors were invited to have limited displays in the reference room the night of our regular meetings was continued this month. He also announced that representatives of Geo. L. Claflin Company, Sharp & Dohme Company, Petrogalar Laboratories, and Ciba Pharmaceutical Products, Inc. were present for the meeting.

The President introduced as the first guest speaker of the evening Dr. C. H. Mann of the Squibb Medical Institute who spoke to the topic "Lymphogranuloma Venerium."

Dr. Mann gave a most enlightening discussion on lymphogranuloma venerium. He traced its history to 1786 at which time John Hunter described a non-venereal bubo not cured by mercury. He stressed the great advance made in differential diagnosis since the Frei test was brought out in 1925 and especially since the antigen has been cultivated by the yolk sac technique in 1940. He discussed the points of resemblance and differentiation of the various members of the lymphogranuloma venerium and psittacosis group which group includes human atypical pneumonia, trachoma, inclusion blenorrhea, mouse pneumonitis, etc. In all of these conditions, he stressed the fact that these disorders gave various cross reactions to the complement fixation test and intradermal test. Lymphogranuloma venerium, trachoma, and inclusion conjunctivitis are all helped by the sulfonamides. Experiments are being made in treating acute cases with antigen also. Tartar Emetic and Fuadin are effective in granuloma inguinalis but not in lymphogranuloma venerium.

The second speaker of the evening was Lt. Comdr. Monroe A. Rosenbloom of the Naval Air Station at Quonset, R. I. who spoke on "The Care of Navy Dependents." Lt. Comdr. Rosenbloom who is in charge of the medical care of Navy dependents in the Quonset area gave a very enlightening talk on the problems encountered in this work.

After Dr. Rosenbloom's presentation Navy motion pictures were shown of the invasion of Guadalcanal and of Tarawa.

The meeting adjourned at 11:20 P. M. Collation was served. Attendance 68.

Respectfully submitted,

FRANK N. DIMMITT, M.D., *Secretary*

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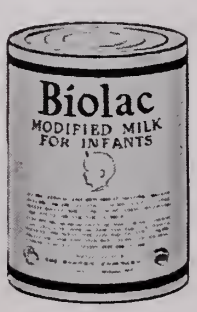
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FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street Providence

ANNUAL MEETING PLANS

Preliminary plans for the annual meeting of the Society indicate that it will be an outstanding assembly this year.

Prominent among the guest speakers who have accepted invitations to address the Society are Dr. Walter C. Alvarez, professor of medicine at the University of Minnesota and consultant in the division of medicine at the Mayo Clinic, Dr. William T. Green, director of clinics of the Harvard Infantile Paralysis Commission, Dr. James R. Miller, chairman of the council of the Connecticut State Medical Society and an outstanding authority on medical care plans, and Dr. John B. Rice, of New York, an outstanding authority on medical research.

An interesting change in the morning programs will be the holding of the Wednesday morning session at the Quonset Naval Air Station, if possible, where a clinical program would be arranged under the direction of our Comdr. William P. Davis, MC, USNR. The Thursday morning program will consist of presentations at the Peters House at Rhode Island Hospital, with contributions by the staffs of the various hospitals in the district.

The afternoon programs at the medical Library will offer outstanding opportunities for acquiring the latest information on current medical and surgical problems, with tropical medicine in the forefront. On Wednesday night, May 24, the annual Charles V. Chapin Oration will be delivered by a physician of national prominence.

DR. F. G. TAGGART HONORED

On February 28 approximately 100 members of the East Greenwich Lions Club and friends of Dr. Fenwick G. Taggart gathered at the Armory to honor him on the occasion of his completion of forty years of faithful service to that community. Tributes were paid to the veteran East Greenwich physician by town and state officials, Navy personnel and members of the medical profession. Dr. Arthur H. Ruggles, superintendent of Butler hospital, was the principal speaker of the occasion.

ELECTIONS AND APPOINTMENTS

Dr. Herman C. Pitts, chairman of the Society's Committee on Cancer, was recently elected as Chairman of the board of directors of the American Society for the Control of Cancer after serving for two years as president of that organization.

During the past month Dr. Charles F. Regan, for more than seven years assistant superintendent of the State Hospital for Mental Diseases, was appointed as superintendent to succeed Dr. John R. Ross who has resigned to return to hospital work in New York state.

The appointment of Professor C. E. A. Winslow, professor of public health at Yale University, as editor of the American Journal of Public Health, effective April 1, has been announced. Dr. Winslow is a former president of the American Public Health Association, and in 1942 he received the Sedgwick Memorial Medal for distinguished service to public health.

CONTINUING TO GROW

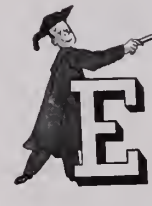
The membership of the Society reached a new high mark during the past month as the campaign to enroll every member of the district societies continued. Elected as Fellows of the Society, and thereby certified as members of the American Medical Association, were the following: Dr. Michael Arciero, Dr. Abe A. Brown, Dr. Arthur B. Cuddy, Dr. Charles P. Earley, Dr. Stephen E. Emidy, Dr. Frank D. Fratantuono, Dr. John P. Hogan, Dr. Israel Kapnick, Dr. Walter H. Potter, Dr. Nicholas A. Pournaras, Dr. Margaret Ross, Dr. Edmund Sydlowski, Dr. Anthony C. Verrone, and Dr. Jacob Warren.

NECROLOGY

WILLIAM R. MCGUIRK, M.D., of Providence

Died, March 12, 1941

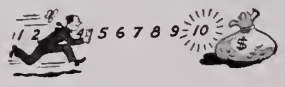
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MEDICAL LIBRARY NOTES

COMMITTEE ON THE LIBRARY:

Herbert G. Partridge, M.D.; Samuel Adelson, M.D.; Adolph W. Eckstein, M.D.

THE Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:—

HOSPITALS

Transactions of the American Hospital Association. 41st, 1939. Chic., 1939. Gift of the Providence Public Library.

INSURANCE

Louis I. Dublin—A Family of Thirty Million. The Story of the Metropolitan Life Insurance Company. N. Y., 1943. Gift of Herbert H. Armington, M.D.

MEDICINE

George F. Dick & others, editors—Yearbook of General Medicine, 1943. Chic., 1943.

SURGERY

H. Winnett Orr—A List of Books and Phamphlets on the History of Surgery and Orthopedic Surgery. Lincoln, Neb., 1943. Gift of H. Winnett Orr, M.D.

THERAPEUTICS

Transactions of the American Therapeutic Society. Vols. 41 & 42, 1941-42. 1943.

BOOK REVIEWS

MANUAL OF FRACTURES: Treatment by External Skeletal Fixation, C. M. Shaor, F.A.C.S. Captain M.C. T.S.N. and Frank C. Kreuz F.A.C.S. Lt. Commander M.C. U.S.N. W. B. Saunders Co. 1943

This new book of 279 pages is really a manual for guidance in the use of the highly publicized "Stader Splint" The book deals with the authors experiences with the new introductions of skeletal fixation. The authors do not state that the use of the Stader splint is a "cure all" for all fractures but they feel that it has distinct advantages over other methods in many types of fractures. They also admit that the use has its own disadvantages.

In the book the pit falls experienced in the early use of the Stader splint are described and the methods by which these handicaps were overcome. The authors are quite frank in admitting the errors that were made and the early discouraging results that had to be corrected.

The application of the splint, the care necessary during its use, and after care are described in detail. Careful reading of the book and the study of illustrations will give enough information for an individual who understand orthopedics and fractures an excellent working basis for the newest type of skeletal fixation of fractures. Of course, individual changes in technique will be adapted to suit each operator's individual idiosyncrasies.

I recommend that every surgeon should read the book to understand the new concept of skeletal fixation. Every orthopedic man should study the technique as he will find it very useful in many selected fractures which now may cause him some headaches. G. EDWARD CRANE, M.D.

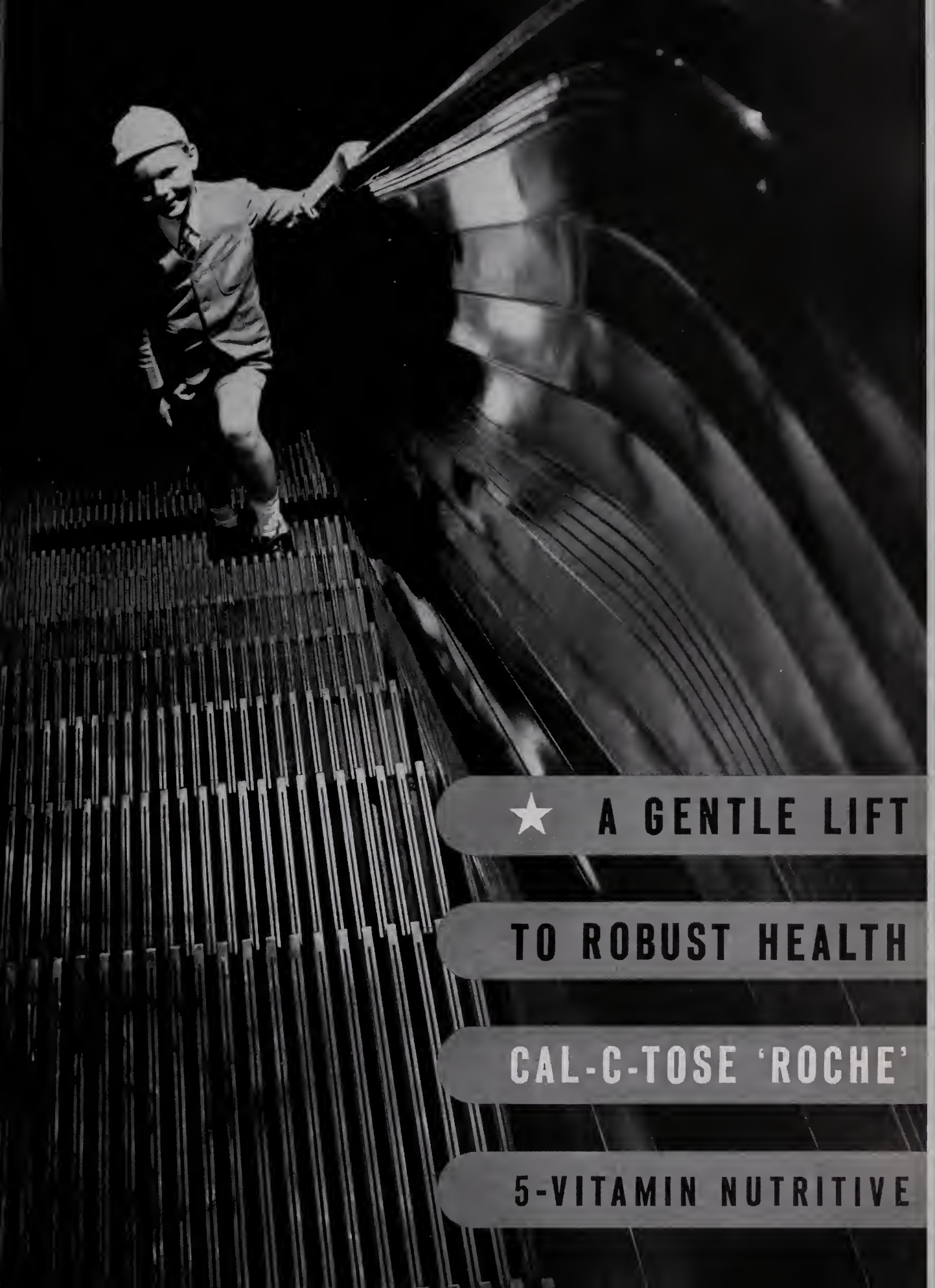
THE YEAR BOOK OF GENERAL MEDICINE 1943. Cloth. $3.00. Pp. 784. The Year Book Publishers, Inc., Chicago, Ill.

To the busy practitioner the Year Book of General Medicine is like manna from heaven. In it he has at his command the year's most important advances in medicine, authoritatively and adequately abstracted. The material is timely and well presented.

War medicine and tropical diseases, as in last year's volume are again given due consideration. The importance of having some knowledge of these conditions becomes more and more apparent as one scans the numerous articles on this subject stressing the epidemiology, recognition and control of same. It is readily admitted with some degree of trepidation that after demobilization of our Armed Forces we in the United States will become heir to many diseases hitherto known to us only in name, and it is also apparent that the physician will have to reorient his impressions and learn to cope with the new problems. The Year Book of Medicine offers him the opportunity to become acquainted with the latest developments in this field.

There are many more new thoughts projected in this year's volume, too numerous to even mention.

continued on page 196


★ A GENTLE LIFT
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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

DOCTORS AT WAR

OFF TO THE WAR FRONTS

The enlistments continue and we note the following doctors who have reported at Carlisle Barracks in Pennsylvania for indoctrination courses: Lieut. Thomas A. Egan, Lieut. Stephen J. Fortunato, and Lieut. William A. Reid, all of Providence; Lieut. Thomas J. Lalor and Lieut. George A. Keegan, both of Woonsocket; and Captain Joseph Wittig of West Warwick.

The Navy has claimed Raymond Luft, of Warwick, who is now a Lieutenant awaiting assignment at New York City, and Lieut. Comdr. Bance Feinberg who is stationed at the U. S. Naval Construction Training Center at Camp Peary in Williamsburg, Va. Prior to his departure Dr. Feinberg was tendered a dinner by the officers and director of the Childrens Heart Association of which he was president, while Dr. Luft, Warwick superintendent of health, was given a farewell party by Warwick city officials and friends.

IN THE PACIFIC ARENA

From Naval Lieutenant William Tully comes a story of life in the Pacific, with mention of an emergency appendectomy performed at sea when "the temperature of the sick bay was over 120, and that is plenty hot when you have a mask and gown on, and everything is closed up tight because of blackout necessity. On top of that," Dr. Tully reports, "the sick bay is about 6x8 (good and small)". An interesting commentary in this communication was that "when you see the size of some of these small places out here and then think of the terrific cost of life it took to take them you begin to realize what a big affair this war is."

From the Arctic to the Tropics might be the title of Lieut. (jg) John P. Hogan's odessy, for he spent a year or more as civilian physician with a company constructing northern air bases before enlisting in the Navy. Now in the Pacific arena, Dr. Hogan reports a recent meeting near Honolulu with a Lieut. Paul Dunn, former Memorial Hospital intern and a Providence resident.

Lt. Comdr. H. Frederic Stephens, a Marine flight surgeon, was recently reported as having walked into a Navy office on a Pacific isle one day where he unexpectedly met his brother-in-law, Lieut. Comdr. Arnold W. VanBenschoten, son of our Dr. VanBenschoten, whom he had not seen for two years.

HEADED FOR TOKIO VIA INDIA

The stepping up of the war in the India-Burma-China theater again focuses our attention on our 48th Unit stationed there. However the Rhode Island Unit no longer holds a monopoly as our only representation in the land of Maharajahs.

Recently we had a message from Captain William A. McIntyre, former Homeopathic intern who spent some time training in Texas, that he left the States last September for India. Sometime ago while on a visit to Calcutta he unexpectedly met Captain Robert Murphy and Captain Edward Damarjian of the Unit, and what a thrill that must have been to encounter familiar faces thousands of miles from Westminster Street! Dr. McIntyre reports that "my life has been pretty rugged so far and I have accumulated a million experiences which I hope I will be able to tell of at some later date."

From the Unit we had word a month ago from Captain William Leet stating one of the former Rhode Island interns with the group desired to apply for membership in the Society. That is truly interest in the profession, and needless to say we dispatched the necessary application forms via air

continued on next page

mail. The executive office was also happy to be of help (we hope) in solving the request of the advance post of the Unit that it might obtain the Journal of the AMA.

From Mrs. Marjorie Grueninger of Cliffside Park, N. J. we learn that her husband is the ENT surgeon with the 48th Unit, and her request for issues of the R. I. Medical Journal is one that we will fulfill with pleasure.

Although we lack complete information, we have been reliably informed that Captain Louis D. Lippitt is now stationed in India, and Captain Nathan Chaset is on assignment in Persia.

ACROSS THE NATION

Captain Morris Botvin has seen much of the country since his enlistment a year and a half ago. After a term at Camp Barkeley in Texas he was assigned successively to Washington University in St. Louis and Walter Reed General Hospital in Washington to pursue the Army's course in maxillo-facial plastic surgery. Then came a turn of duty at Fort Sill, Oklahoma, where he is a member of the EENT staff of the station hospital, and where he qualified in the examinations as a Fellow of the American Board of Ophthalmology.

From Rome, Georgia, comes word that Lieut. Elihu Saklad is chief of the anesthesia section at the Battey General Hospital there, and from the Barnes General Hospital in Vancouver, Washington we have had a lengthy message from Captain A. F. Melucci, stationed there, relative to the attitude of the Army regarding recent public discussions of socializing medicine.

PREPARING FOR THE INVASION

The number of Rhode Island doctors in England continues to grow, and indications point to a sizable representation there who will undoubtedly play important roles in the care of the forces that will invade fortress Europe in the not too distant future. Some time ago we heard from Lieut. Dave Freedman that he had participated in some general surgery at local hospitals and for a time Captain Parker Mills was attached to his station hospital unit.

Others who have been reported as stationed in the British Isles are Captain Kenneth G. Burton, Major Hugh Kiene, Captain John T. Keohane, who reports he is "enjoyng England so far as the weather has been quite mild but pretty damp." Captain R. S. Arlen, who is attached to

continued on page 190

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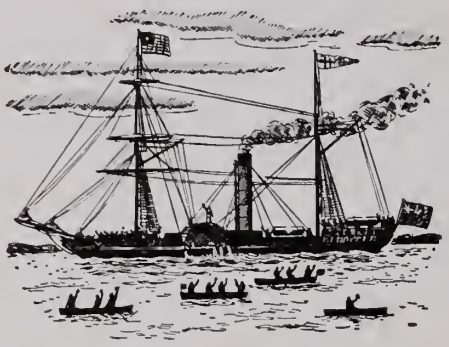
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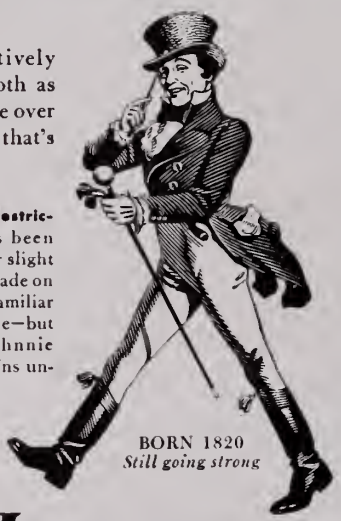


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DOCTORS AT WAR

continued from page 188

a fighter squadron and also has completed military courses at Oxford preparatory to teaching aviation medicine to prospective flight surgeons, and LIEUT. ALPHONSE R. CARDI who reports that he has received the R. I. Medical Journal and enjoys it immensely.

IN THE TROPICS

We are still trying to locate LIEUT. WHITMAN MERRILL, USNR, who was for a time at Balboa in the Canal Zone, but is now reportedly on foreign duty elsewhere. And the last report we had from MAJOR H. A. CAMPBELL was that he was still on foreign service in the tropics but anticipating a transfer any day.

SERVICE ON THE HOME FRONT

In the presence of State and City officials twenty eight physicians, surgeons and dentists of the Selective Service induction station were presented emblems by the government in recognition of their services. The emblems, awarded by Brig. Gen. Herbert R. Dean, State Director of Selective Service, were given for "meritorious and faithful service."

Emblems were presented to the following: Drs. Kathleen M. Barr, Albert A. Barrows, Ernest A. Barrows, Peter P. Chase, Charles O. Cooke, Edward Crane, James P. Deery, William Fain, Frank D. Fantantuono, Nora P. Gillis, Jacob Greenstein, James E. Heap, Robert T. Henry, Clifton B. Leech, Walter I. McIntire, Benjamin S. McKendall.

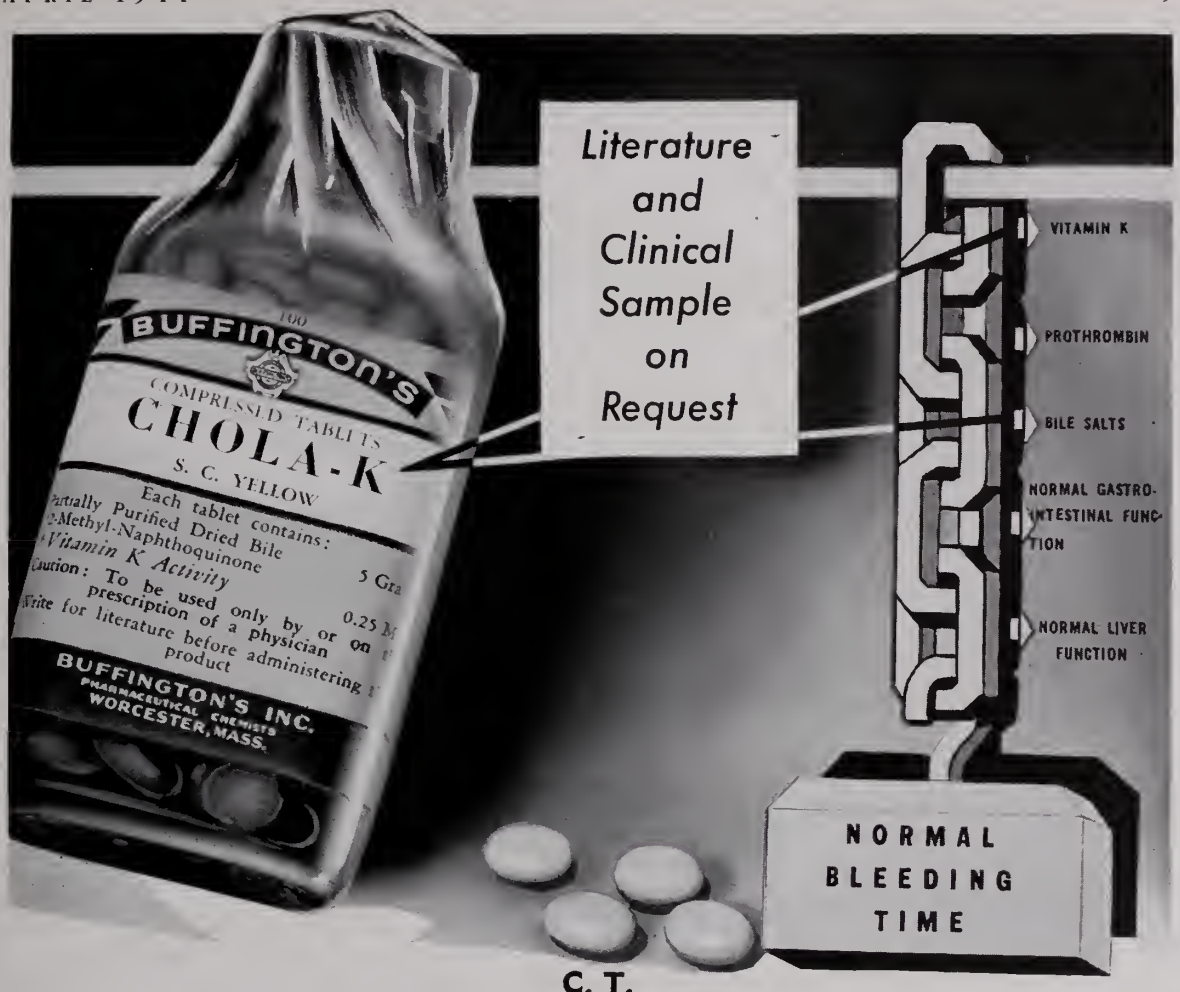
Also Alan E. O'Donnell, Edwin B. O'Reilly, John A. Paterson, Melba Perley, Lewis B. Porter, Ernest Quesnel, John F. Regan, Mark Rittner, Robert C. Robinson, Harvey B. Sanborn, Charles E. White and Clarence H. Woodmansee.

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- Hemorrhagic state associated with Primary Hepatic Disease
- Hemorrhagic conditions of Ulcerative Colitis, Sprue and Celiac Disease
- Hypoprothrombinemia of the Newborn

References

AGGELER, P. M. and LUCIA, S. P.: The Bleeding Tendency in Diseases of the Liver and Biliary Passages, Acta Medica Scandinavica, 107:179 May 1941.

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**Loose, ill-fitting dentures are usually the result of changed bone and tissue formation. In severe cases the patient should, of course, see his dentist.*

DR. WERNET'S POWDER

Holds dentures firmly and comfortably in place



FORWARD MARCH OF DENTISTRY

continued from page 173

The International Association for Dental Research, organized twenty-three year ago, has won world-wide distinction by its notable achievements and affiliations, and by its scholarly *Journal of Dental Research*. The American College of Dentists offers the William John Gies Research Followships and Grants-in-aid, and has made an initial award for outstanding achievement in research. Not only does the patient work of minute investigation clarify the problems and extend the resources of dental practice, but it also opens the eyes and stimulates the mind of the dentist in his office, deepens his sense of the dignity of his calling, awakens the hope that his own observations may add to the total of professional knowledge; and it makes him vitally interested in the dissemination of such knowledge by means of dental literature. Dental minds are everywhere alert. Dentistry is indeed alive and growing under the inspiration of expanding opportunity and public recognition of the fact that it is a specially-equipped health-service profession.

Educational and Legislative Advances

Schools, state examining boards and dental societies have achieved and maintained new levels of interest and proficiency. The importance and values of dentistry have penetrated much deeper into the consciousness of universities, medical schools, hospitals, dispensaries, public-health agencies, mothers' clubs, teachers' associations, and the unorganized public. The interest of universities and medical schools in the need of a well-rounded curriculum and program of research has been newly awakened. Many and varied problems of teaching and administration, of helpful alliances and correlations, of acquiring and disbursing adequate funds for the advancement of learning, have been thoroughly canvassed and are apparently solved or well advanced toward solution. High purpose, unified effort, and a dauntless will to succeed have characterized each step in each activity. The seed is sown, and we believe that the harvest will not fail.

Many of the dental statutes have been so completely and effectively revised that the results already attained in the elimination of unworthy practices deserve the highest praise. Some of them are looked upon as models of dental legislative perfection: they are comprehensively drawn, clearly stated, and leave no loopholes for prospective violators or the cheap practices of their wily lawyers, who formerly evaded or nullified the intent and spirit of the law.

Items that have helped to bring dental legislation to a high degree of efficiency are: (a) a more complete and precise definition of dental practice and its domain—a masterful curb on the ever-ambitious mechanics, and a bar to all who have not qualified under the course of study prescribed as acceptable; (b) an iron-clad clause pertaining to American citizenship, which will keep out incompetents from Europe and elsewhere; and (c) the relegation of advertising, in the public press and in others ways, to oblivion.

The forward march of dentistry during recent years is due to the poise, confidence and energy of an enlightened dental leadership, which, under capable direction and by means of planned effort toward well-defined objectives, has not only achieved its immediate ends, but has moved forward so forcefully and consistently as to merit widespread approbation. Educational institutions, the

continued on page 195

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IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg.

*Each serving made with 8 oz. of milk; based on average reported values for milk.

FORWARD MARCH OF DENTISTRY

continued from page 193

medical and other professions, hospitals, public-health agencies, federal, state and local governments, and also a considerable part of the general public, recognize that dentistry is a willing, competent and indispensable agent of health service.

In all the effort we have expended to secure a more thorough and well-rounded education for dentists, to awaken the spirit of scientific research, to clear ourselves of encumbrances, strengthen our foundations, build up the opportunity, influence, dignity and solidarity of dentistry, we have done no more than meet our professional obligations as they have become clear to us, and satisfy a resolute purpose to excel.

Meeting New Challenges

The most vital test of any profession is summed up in the two queries: Is it efficient? Is it progressive? It is safe to predict that the answer to the first will soon be "no" unless the answer to the second is "yes". A progressive profession is one which strives earnestly, under its ideal of ceaseless growth, to maintain the highest standard of excellence in its service, not only by meeting all present demands, but by anticipating those of the future, and by accepting with enthusiasm the challenge of new truth and increased responsibility. For, like every other thing that lives and seeks to grow, dentistry, today and every day, must face the problem of adjusting itself to an ever-changing environment. That this is now and has been the philosophy of dental leadership since 1910 may be gleaned through reflection upon the extent, content and quality of dentistry's progress and attainments since that time.

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Capt. Louis Pomiansky, DC, Co. D-366 Med. Corps, 66th Inf. Div., Camp Jos. T. Robinson, Arkansas.

Lt. (j.g.) LeRoy Fishman, DC, USNR, U. S. Marine Air Station, Pollocksville Field, New Benu, North Carolina.

Capt. Michael B. Messore, DC, Station Hospital, Hunter Field, Georgia.

Lieut. Gerard P. Archambault, DC, USNR, Naval Base, Fishers Island, New York.

Capt. Raymond Lapolla, DC, Station Hospital, D. C., Camp Mackall, North Carolina.

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BOOK REVIEWS

continued from page 184

However, one cannot refrain from citing some of the high spots that are evident throughout the book.

The efficacy of the sulfonomides, tyrothricin and pencillin is briefly presented, and their limitations and toxid manifestations are mentioned; the pulmonary lesions encountered in the Cocoanut Grove disaster are described in detail; the clinical and experimental work done on the various types of pneumonias during the year are well summarized; the impression gained from the use of anti-coagulents, particularly dicoumarin, a preparation from spoiled sweet clover, is clearly set forth with the method of administration, its effect on prothrombin time and danger signals given.

All in all this reviewer feels that the Year Book of General Medicine deserves desk space in the office of every physician.

Louis I. Kramer

CANCER AND WORKMEN'S COMPENSATION ACTS

continued from page 175

cancer in an individual as to accelerate and aggravate it, resulting in disability or death, the claims were allowed. This stands as cancer due to accidental injury.

Determining Factors

Rubenstein gives four elements which must be present in each case where an *injury* caused the cancer.

1. Serious injury or strain.
2. Physical causal connection between the injury and the disability or death.
3. Proper lapse of time between the injury and the disability or death.
4. Employee free from cancer at the time of injury.

Where injury *aggravated and accelerated* the pre-existing cancer.

1. Ordinary type of injury.
2. Physical causal connection between the injury and the disability or death.
3. Proper lapse of time between the injury and the disability or death.
4. Employee suffering from dormant or active cancer at the time of injury.

In every case where all of these elements were not present the compensation was denied.

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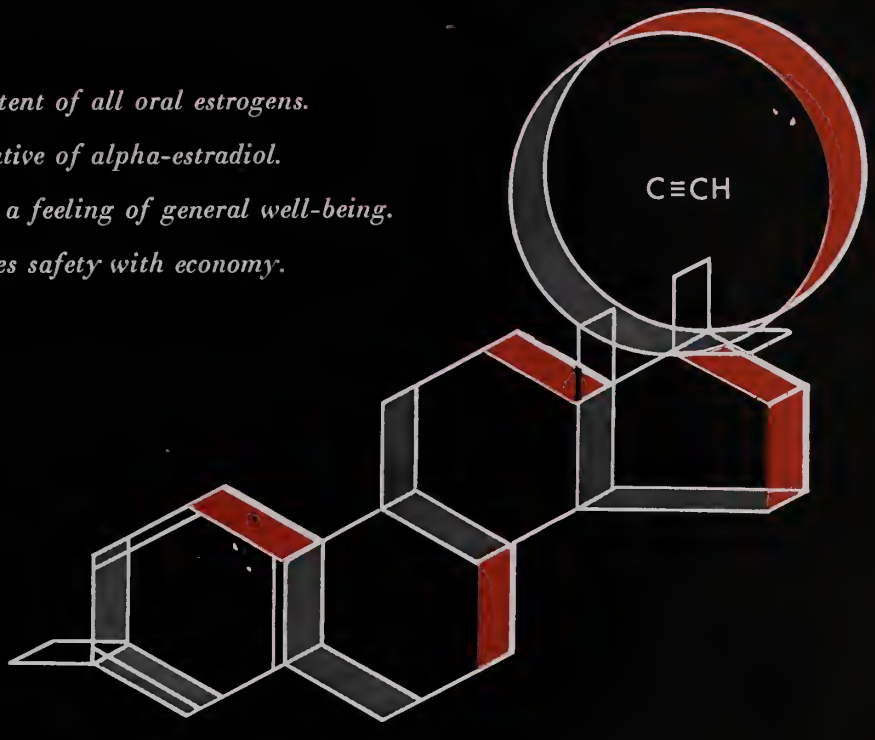
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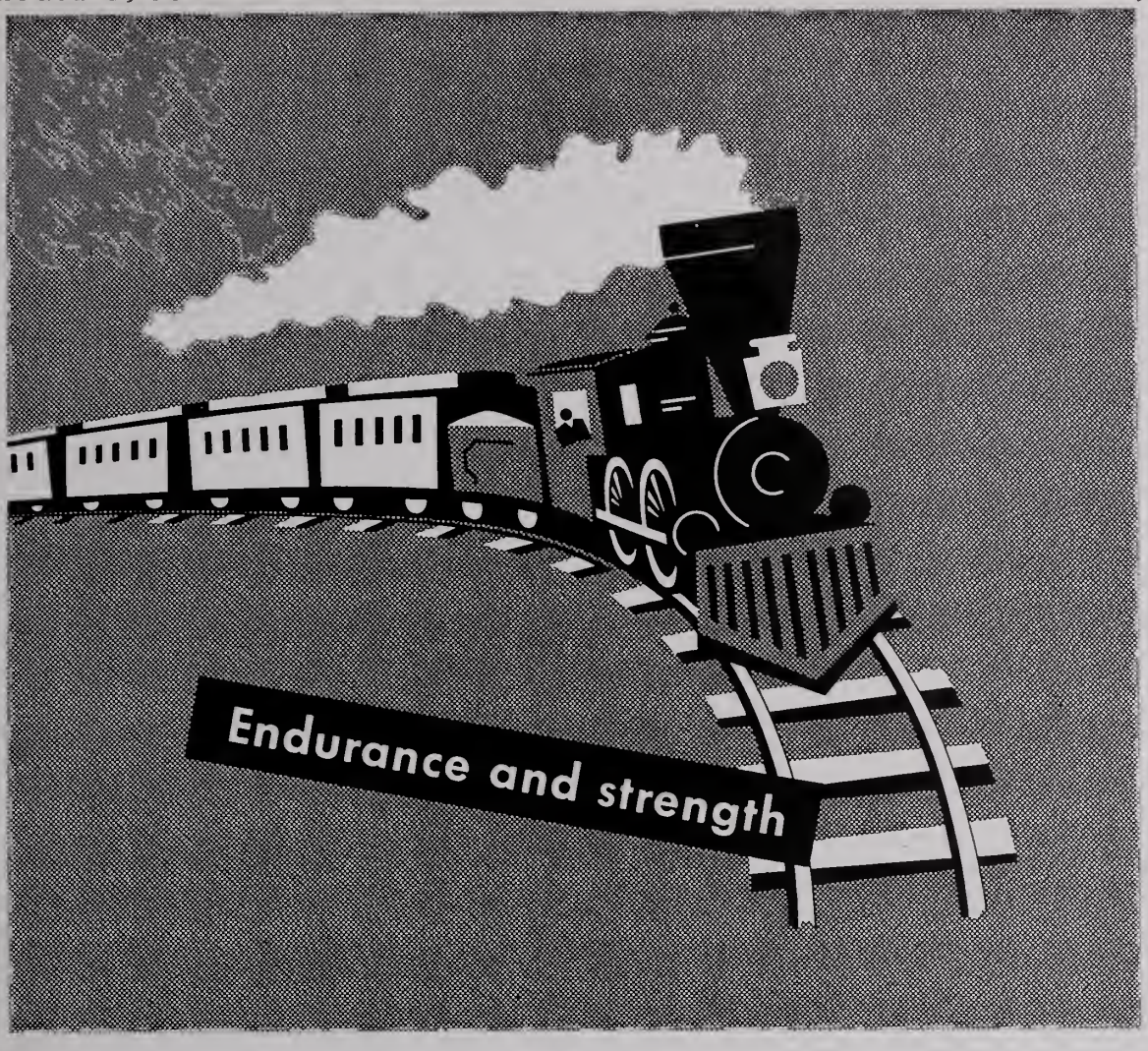
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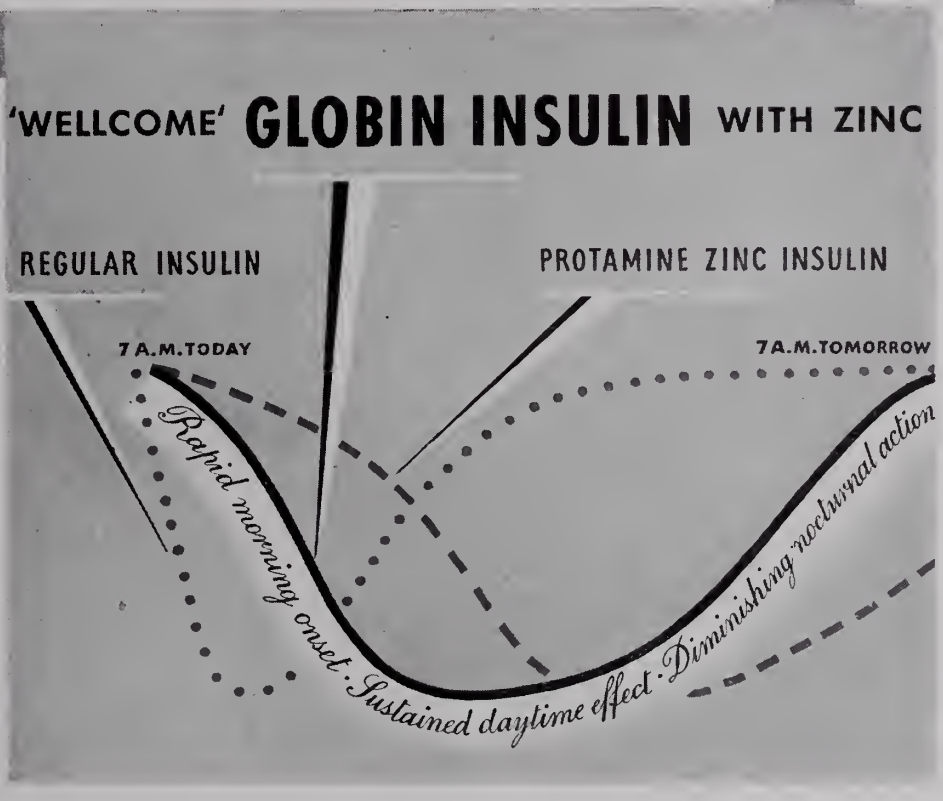
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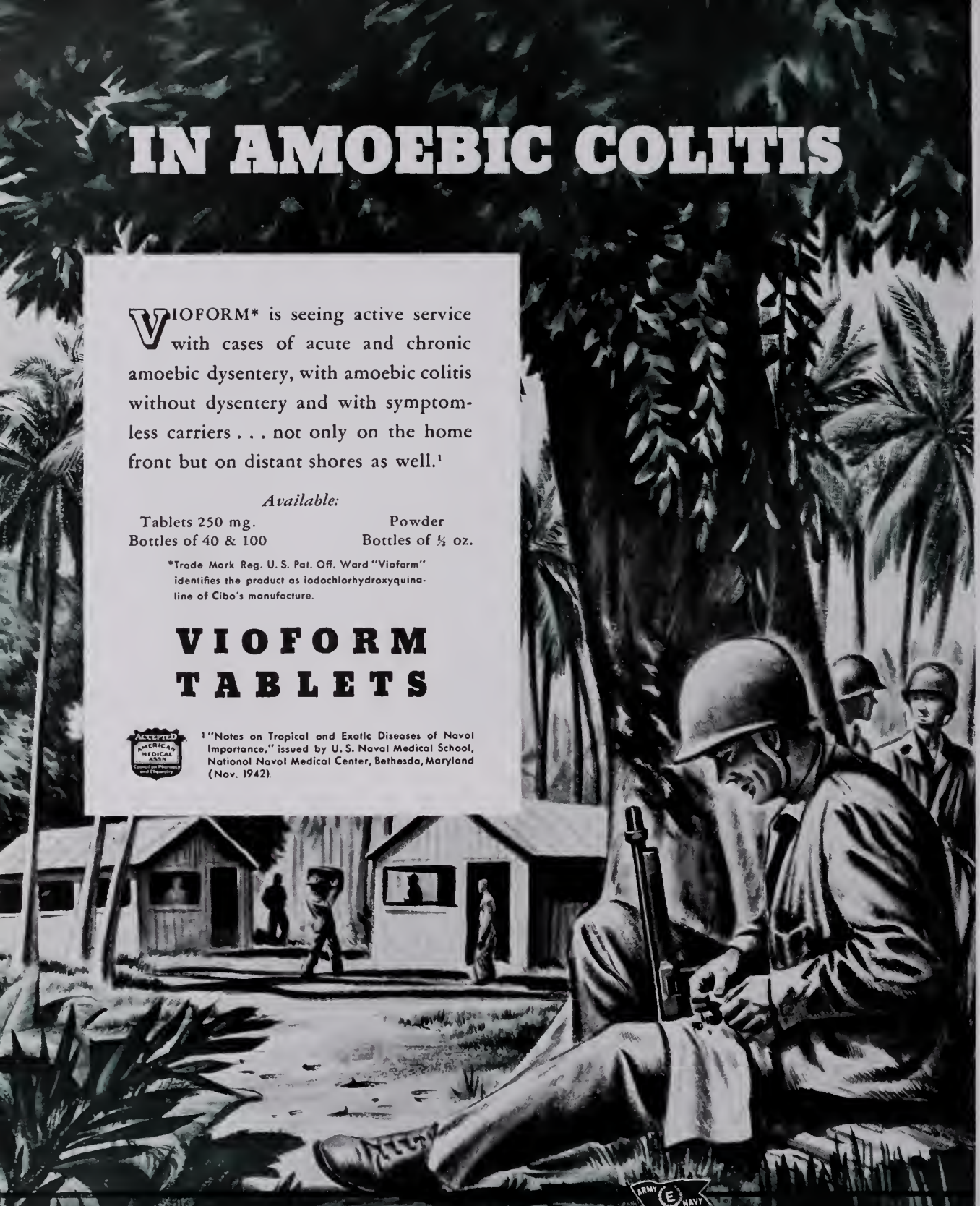
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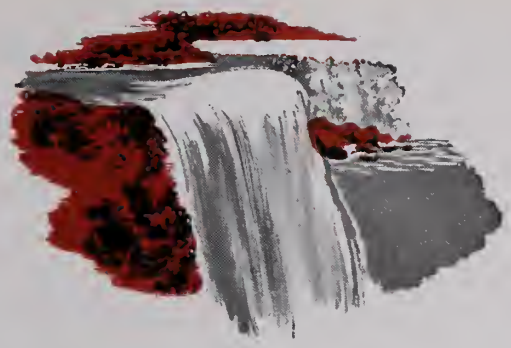
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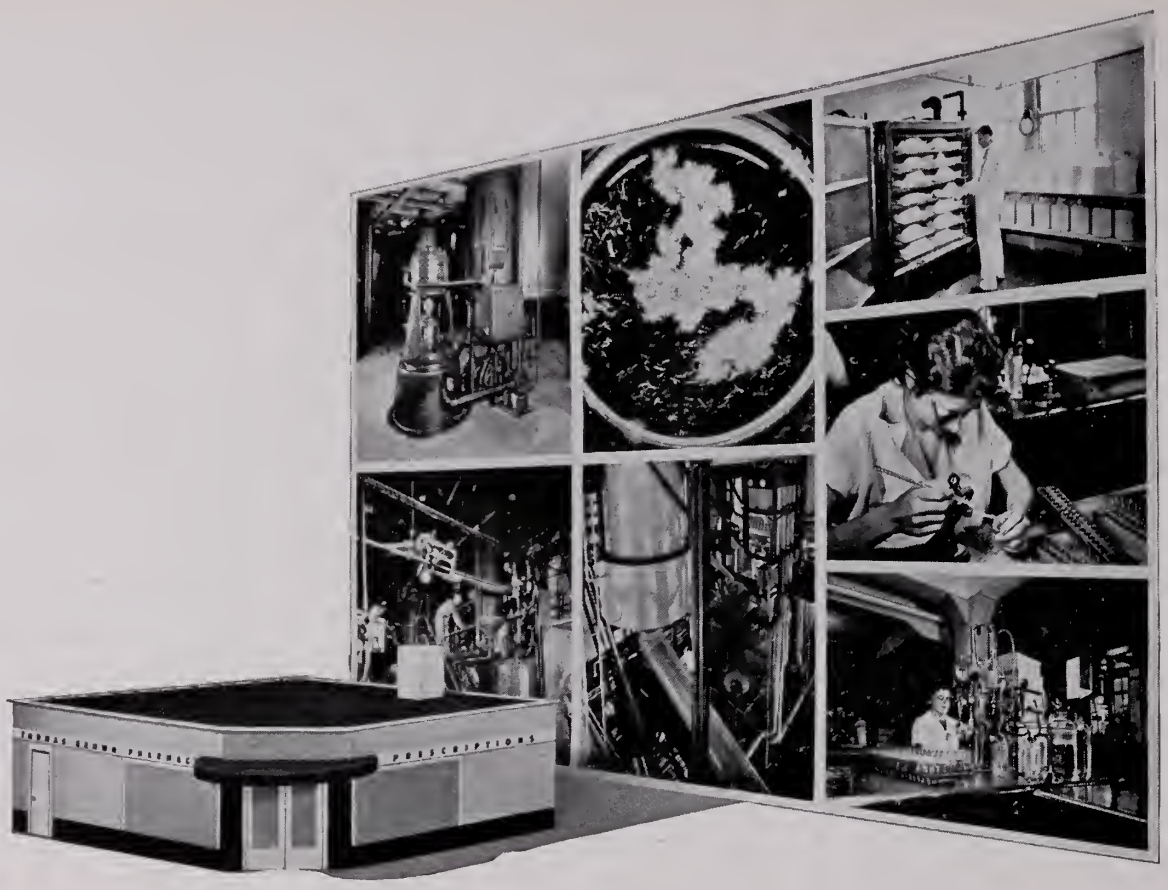
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVII MAY, 1944 No. 5

NEWER DEVELOPMENTS IN THE CLINICAL AND LABORATORY ASPECTS OF LYMPHOGRANULOMA VENEREUM

CHARLES H. MANN, JR., M.D., DR.PH.

The Author. *Charles H. Mann, Jr., M.D., Dr.P.H., Former Epidemiologist, Massachusetts State Department of Health; Former Instructor, Public Health and Preventive Medicine, University of Michigan School of Public Health; Former Director of Communicable Diseases and Epidemiology, Idaho Department of Health; Director of Investigation of Anti-venereal Disease Products for E. R. Squibb & Sons, New York City.*

INTRODUCTION

DURING the past several years reports have come out of various countries indicating that lymphogranuloma venereum has world-wide distribution. The extent of this distribution, however, has been difficult to ascertain because of the confusion concerning terminology. Such synonyms as tropical or climatic bubo, lymphogranuloma inguinale or poradenitis, venereal lymphogranuloma, esthiomene, lupus vulvae, non-tuberculous granulomatous lymphadenitis, strumous or scrofulous bubo, chronic elephantiasis with vulvar ulceration, inflammatory stricture of the rectum, Nicolas-Favre disease, Fourth Venereal Disease and a Sixth Venereal Disease have been used at one time or another to designate the clinical syndrome which is now recognized generally as lymphogranuloma venereum.

The present day clinician is confronted by another problem associated with the early recognition of lymphogranuloma venereum. This involves the difficulty of recognizing it in the early or latent stages because of the frequency with which it is masked by the presence of other venereal diseases. In some cases the lesions are so similar to those of the other diseases transmitted by sexual intercourse that accurate diagnosis is practically impossible without the aid of a specific test. Recent publications on lymphogranuloma venereum have shown that earlier concepts concerning the causative agent, diagnosis, epidemiology and treatment of this disease were inaccurate in many respects, and it now becomes evident that methods of control must be altered to conform to the newer knowledge.

In the United States the known incidence of this venereal disease has justified further investigation of the laboratory and clinical aspects, and its recognition is being greatly simplified by the more general use of the intradermal and complement-fixation serologic diagnostic tests.

DEFINITION

Lymphogranuloma venereum may be defined as a wide-spread communicable disease usually acquired venereally. It is caused by a specific filtrable agent which can bring about infection in certain experimental animals. The infective agent usually gains entrance to the body through the skin or mucous membranes of the external genitalia or ano-rectal region. Usually, although not always, a small transitory herpetiform lesion is produced at the point of entrance. It may also gain entrance through the mouth or conjunctiva and rarely through other extragenital tissues. The incubation period is not firmly established but is considered to be from 1 to 3 weeks.

It is probable that the disease is much more common than is generally supposed, and perhaps more benign, with a natural tendency to spontaneous cure. It affects all races but shows greater incidence among the colored people in the United States. A higher incidence has been reported in males than in females although this may be apparent rather than real. The disease occurs more frequently within the age limits of greater sexual activity. Surveys indicate that a comparatively high percentage of those sexually promiscuous have been infected.

HISTORY

The history of lymphogranuloma venereum is little different from that of other venereal diseases,

continued on next page

Presented at the meeting of the Providence Medical Association on March 6, 1944.

inasmuch as it indicates that physicians of keen insight practicing as early as the latter part of the eighteenth century, observed that certain clinical entities occurred which differed in some respects from the manifestations of typical syphilis and showing no apparent response to the therapy then in vogue for spirochetal infection. In 1786, John Hunter described a condition in which buboes developed without apparent cause, were unaffected by mercury, and responded to salt water treatment. William Wallace, in 1833, accurately described what would now be regarded as a chronic suppurative case of the inguinal variety of the disease.[1]

During the years 1894 to 1896 this disease was thought to be due to climatic influences (chiefly tropical) and it was consequently named "climatic bubo." Rost, a German naval medical officer, in 1912 observed that midshipmen who went ashore in tropical ports under supervision never contracted "climatic bubo" but that the older marines who went alone did contract it; therefore, he suspected this bubo to be not of climatic but of venereal origin.[2]

In 1913, Durand, Nicolas and Favre[3] published their results of an 8-year study on clinical and pathologic aspects of a number of cases. They believed, erroneously, that the close resemblance of the histologic picture of Hodgkin's disease, or lymphogranulomatosis, to that of lymphogranuloma venereum warranted their introduction of the term "lymphogranuloma inguinale."

In 1925 Frei[4] introduced a specific skin test which opened the way for accurate identification of the disease. In his opinion, this discovery and that which he and Koppel found the relationship of esthiomene (from the Greek, meaning eating or eroding) and rectal stricture to venereal lymphogranuloma marked the end of the second step toward gaining definite knowledge about the disease. The third step, he states, "was the transmission of the disease to animals, especially through intracerebral inoculation of monkeys, by the Swedish scientists Hellerström and Wassen, in 1930. Their work has been continued by many investigators; above all by Levaditi, who introduced the mouse as the most suitable animal for the purpose and who was the first to demonstrate virucidal antibodies in the blood serum of infected men and animals."

In 1934 Grace and Suskind[5] introduced the use of the mouse brain infected with lymphogranuloma venereum as a cultural source of antigen for the intradermal test. This antigen of greater availability provided freedom from the several disadvantages associated with the utilization of human pus, but it was not the ideal product because a high percentage of the mouse brain controls gave nonspecific reactions, even though these were distinguishable from positive reactions. Further disadvantages were shown in the fact that the concentration of the agent in the brains of diseased mice is not high, and the possibility that antigens of animal origin may sometimes sensitize individuals to the animal proteins contained therein.

The final step in investigating the disease is now being taken, and is directed principally toward the cultivation and microscopic examination of the agent along lines similar to those being followed in investigating the agents of other diseases.

Noteworthy contributions in this newer field of investigation are those of Rake, McKee and Shaffer[6] of The Squibb Institute for Medical Research who, utilizing the technique of Cox[7] of the National Institute of Health, have cultivated the agent in the yolk sac of the embryonated chicken's egg and have obtained concentrated suspensions of elementary bodies. In this manner a highly purified and specific antigent, known as Lygranum S. T., has been prepared. It is rapidly supplanting antigens prepared from either human pus or infected mouse brain, for use in the Intradermal Test. These workers, alone[8] and in collaboration with Grace[9] have successfully used the yolk-sac antigen for the complement-fixation testing of the serum of infected patients. The specificity and sensitivity of this antigen (Lygranum C. F.) provides an additional means of detecting early cases of lymphogranuloma venereum.

Newer Aspects of Etiology

For more than three years some very revealing studies of the etiological agent associated with lymphogranuloma venereum have been carried on by Rake and his associates at The Squibb Institute for Medical Research. These workers have observed that there are similarities and differences among members of the lymphogranuloma-psittacosis group of infective agents, including the agents of lymphogranuloma venereum, trachoma, inclusion conjunctivitis or blennorrhea, psittacosis, human atypical or so-called virus pneumonia, acute meningo-pneumonitis and, experimentally, that of mouse pneumonitis. Microscopic examination of the various tissues infected with the agents of this group of diseases reveals striking morphological similarities as shown by the presence of elementary bodies (measuring 125-250 mu in diameter) and

which are easily seen at 1800 magnifications. Cyclical development of the various agents may also be observed with the exception of the agent of human atypical pneumonia which undoubtedly is somewhat smaller in size and occurs in many types similar in this respect to the types of pneumococcic pneumonia and that of acute meningo-pneumonitis which probably goes through such a cycle.

The tinctorial characteristics of these various agents show that all of them are gram-negative, all take on Giemsa's stain, and all, with the exception of the agent of trachoma and that of inclusion blennorrhea, accept Macchiavello's stain. A positive glycogen reaction is obtained in trachoma and inclusion blennorrhea but it does not occur in lymphogranuloma venereum and psittacosis. A remarkable predilection for certain types of tissues is exhibited by these various agents. The agent of lymphogranuloma venereum may attack genital, granulomatous, ocular and meningeal tissues; the agent of trachoma, ocular tissue; the agent of inclusion blennorrhea, ocular and genital tissues; the agent of psittacosis, lung tissue, and the agent of human atypical pneumonia, lung and meningeal tissues. Similar observations have been made on rodents and birds in all the diseases except trachoma and inclusion blennorrhea.

Similarities and differences exist among the various agents with regard to cultural characteristics. It has been repeatedly demonstrated that the agents of lymphogranuloma venereum, psittacosis and acute meningo-pneumonitis grow exceptionally well in the yolk sac of the developing chick embryo.

The problem of the control of all of these diseases with the exception of human atypical pneumonia becomes of greater importance when it is realized that a carrier state can occur. In other words, it is possible for the individual to harbor the agents of the several diseases without manifesting symptoms characteristic of them.

Further similarities and differences are demonstrated by the occurrence of cross reactions when the yolk-sac antigen of lymphogranuloma venereum is used in complement-fixation testing of the blood obtained from patients with any of the other diseases mentioned. The intradermal test performed with the yolk-sac antigen is known to cause a cross reaction with human atypical pneumonia cases, although this does not always occur probably because of the many different types which are associated with the disease.

The chemotherapeutic activity of sulfonamides on members of the lymphogranuloma-psittacosis group indicates that the agents of lymphogranuloma venereum, trachoma and inclusion conjunctivitis all show susceptibility, while those of atypical pneumonia, acute meningo-pneumonitis and psittacosis are not so influenced.

In view of these apparently unique characteristics, it seems justifiable to suggest that the agents belonging to the group, including the causative agents of lymphogranuloma venereum, trachoma, psittacosis, mouse pneumonitis, inclusion blennorrhea and certain atypical pneumonias in man, should be reclassified as the Lymphogranuloma-Psittacosis group to distinguish them, for practical purposes, from typical viruses.

Clinical Aspects

The clinical manifestations associated with infections caused by the agent of lymphogranuloma venereum have been described by many investigators. The observations of these individuals have been somewhat similar but there is some variation of opinion concerning the frequency with which the disease is manifested in different regions of the body. Nevertheless, it is generally agreed that the local manifestations of lymphogranuloma provide important clinical information which, in association with diagnostic tests, constitute the most reliable method of arriving at a correct diagnosis.

From one to three weeks after exposure the first clinical manifestation as commonly acquired by sexual intercourse, is the appearance of the primary or initial lesion (the so-called lymphogranulomatous chancre) at the portal of entry, usually on the genitalia. This lesion has been described[10] as a small herpetiform vesicle or ulcer, with clean edges and a whitish-gray base, circular or lenticular in shape, sometimes multiple, usually inconspicuous,[11] frequently transitory,[12] and often unobserved by the patient.

This lesion may last from three to twenty days but it is usually evanescent leaving no scar to indicate its occurrence. It apparently clears up without therapy. In some cases, however, it may become ulcerative bringing about erosive types of penile lesions, erosive vulval and vaginal lesions including esthiomene, elephantiasis of external genitalia and abacterial urethritis.

The inguinal variety of the disease usually occurs 10 to 30 days or even longer after exposure. Inguinal adenopathy is usually unilateral, but one-third of the cases show bilateral involvement. Inguinal buboes completely regress in about 20 to 25 percent of the patients who have received no

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therapy, but the majority go on to suppuration with resultant formation of multiple sinuses and fistulae.[13] The disease in the suppurative phase becomes chronic and has been very resistant to any form of therapy.

The pelvic variety of the disease occurs particularly in the female following the involvement of the femoral lymph nodes which drain from the infected region of the vagina resulting in the spread of the agent by way of the lymphatics towards the perirectal glands.

Grace and Henry[14] and also Frei[2] have shown that most of the males suffering from the anorectal type of the disease have brought about the direct implantation of the agent in the anal or rectal mucosa through the practice of sodomy. It has been reported,[15] also, that adults and children of both sexes may acquire infection of the lower bowel by use of an enema tip which has been utilized by a person with the anorectal type of the disease. This has been demonstrated experimentally in the chimpanzee by Levaditi,[16] whose observations aid in confirming the belief that the mucosa of the lowest portion of the bowel provides an excellent medium for the growth of the agent of lymphogranuloma venereum.

In the female, some authorities[17] believe that rectal involvement apparently takes place as a direct extension of lymphogranuloma by way of the lymphatic vessels from the vagina to the rectum. A different viewpoint on the mode of acquisition of the anorectal type is offered by Bensaude and Lambling,[18] who are of the opinion that the disease begins in the perirectal tissues and spreads through the rectal wall into the mucosa. This is supported by their examination of 80 women with rectal stricture, of whom only 12 showed accompanying inflammation of the rectal mucosa. These authors reported, further, that in those patients with anorectal lymphogranuloma showing stricture and proctitis it could be assumed that the infection began in the rectal mucosa, and in those with stricture alone it began outside the rectal wall and traveled through to the mucosa.

Although reports of the occurrence of extragenital infections are few, recent evidence shows that such do take place with perhaps greater frequency than was previously believed. The earliest report was that by Klotz,[19] who described the case of a surgeon who was infected accidentally as evidenced by the development of a bubo in the axilla. Similar reports have been made by Hellerström[20] and Phylactos.[21] In 1921, Ravaut and Scheikevitch[22] reported 3 cases of lymphogranuloma which showed cervical adenitis, and they suggested that the tonsil might be the portal of entry of the agent. The diagnosis of these cases was doubtful, however, and but little attention was given to these observations. In 1931, Buschke, Boss and von Vasarhely[23] described a case of lingual lymphogranuloma, the accuracy of the diagnosis of which merits general acceptance. These authors observed that a man, 3 weeks after practicing cunnilingus, developed two small lesions on the side of the tongue and, in 5 weeks, a mass of enlarged glands on the side of the neck. Recently Harrop, Rake and Shaffer[24] have reported the occurrence of four cases among laboratory workers. It seems probable to these observers that two of the patients with cervical lymphangitis were infected via the upper respiratory tract and the third patient possibly through the skin of the hands.

Infections of the eye due to lymphogranuloma venereum have occurred, although very infrequently. Such infections, known as Parinaud's conjunctivitis, were originally reported by Levaditi, Bollack, Basch and Desvignes,[25] in 1936. Their article, titled "Conjunctivitis Without Adenopathy Due to the Virus of Nicolas-Favre Disease," is self-explanatory.

Another case of this type of infection has since been reported by Curth and his colleagues.[26]

Reports on localization of the agent of lymphogranuloma venereum in the meninges are exceedingly rare. The first such report was made by Chevallier and Bernard[27] (1932). A more recent report by Sabin and Aring[28] more completely establishes the diagnosis of meningoencephalitis caused by the agent of lymphogranuloma than does the earlier report of the French observers.

Constitutional Symptoms

Although the constitutional symptoms of lymphogranuloma venereum vary from patient to patient, it is generally believed that they are rarely absent during the stage of invasion of the lymphatic glands. Evidence that the inguinal region is involved is shown by the enlarged lymph nodes. In cases of anorectal involvement, the lesions occur approximately one month after the appearance of the anal discharge. The majority of the cases acquired by venereal exposure appear to be local or limited in nature, devoid of the acute systemic invasion phase. This latter phase probably occurs either when a large infecting dose of the agent is sustained in the body or when it is widely spread from the portal of entry. The antibodies appear

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BLOOD TRANSFUSION AND THE BLOOD BANK IN THE SMALL HOSPITAL

ORLAND F. SMITH, M.D.

The Author. *Orland F. Smith, M.D., Transfusionist, Memorial Hospital, Pawtucket.*

THE organization and maintenance of a blood bank in a small hospital is not possible without many difficulties. The grade of work, however, needs never to suffer, and progress is continuous with the closer cooperation of the staff and personnel.

The Pawtucket Memorial Hospital has a capacity of 166 beds, and yet has had a successfully operated blood bank for the past six years. During this time more than 2000 transfusions have been given. No deaths have occurred that could be attributed to the transfusion, and the total reactions of all types observed have been 4%, which is well under the 8% average generally accepted. This factor probably has been accounted for by an alert and very efficient laboratory staff, together with the meticulous attention to detail so necessary by other departments in carrying out the established routines in the preparation of a whole blood or plasma transfusion. The procedures which have functioned so smoothly and which have succeeded to the satisfaction of the entire Medical Staff are to be outlined.

The most serious difficulty in the maintenance of a blood bank is keeping the bank solvent. Patients who are given a blood transfusion have never been particularly interested in the source of the blood. The replacement of a pint of blood by a family seems very little to ask, and yet always proves to be a continual obstacle to the success of the bank. Then there are those people who have no close friends or relatives who might be asked to replace the blood or plasma. It seems many times as though these are the people that require multiple transfusions. They are also the same people who increase hospital deficits as well as strain the solvency of the blood bank. We have struggled with the donor problem since the inception of the bank, trying various community groups—pleading, begging and at times threatening relatives, and ending up against the same blank wall after an era of brief prosperity. The idea of buying blood has been entertained, and with two colleges close by this would be a possible satisfactory solution, but most of the students are members of a Navy or Army group, and either are not interested or are not permitted to indulge in such extra curricula activities as acting as blood donors.

The charge of $35.00 ($25.00 for ward patients) for a pint of blood has never dampened the attitude of the patient. Thirty-five dollars seems such a small sum even for the average worker today that they prefer to pay the bill in cash rather than blood. Many times have I made the statement that we cannot inject $35.00 into the veins of a dying man.

The service charge is $5.00 and the balance is payable if no blood donors are provided. $15.00 credit is allowed for each of the two bloods normally required to replace the blood used. The decision to require two donors to replace the blood given instead of three was made after a careful study of the averages attained in replacement during the years 1941 and 1942. During those years we required three donors for each transfusion, but the actual number of donors was 1.51 for each blood. On cutting down the required replacement donors from three to two the average jumped to 1.6 in 1943. This figure still was too small to increase the plasma reserve very fast.

Those facts and figures should also be the means of explaining to the minority staff member why more than one blood is necessary to replace the pint given to the patient in trouble.

Industrialization of Bank

The decision to industrialize the blood bank was made and the personnel directors of several industrial plants in the community were interviewed. The proposal in brief was for these plants to insure the solvency of the blood bank by supplying donors per year equivalent to ten per cent of their employees. The results after six months have indeed been most gratifying. The continual supply of blood has continued to flow, and new plants are

continued on next page

eager to be included. The ten per cent figure now seems higher than necessary and eventually five per cent will be closer to the requirements if it continues to thrive. In return for these bloods donated, all of the employees of the cooperating plants and their families are given credit of 50% of the required donor replacement for every transfusion given them while patients in the Memorial Hospital. As the program goes into the second half-year it appears that the benefits can be increased to 100% for these industrial groups and their families. The experience of donors to the Red Cross has done much to dispel fear among the prospective donors to the hospital.

The training of two graduate nurses was completed in a relatively short time and the technical work is done entirely by them, in addition to their other hospital duties. The blood is collected in the flasks prepared by the Cutter Laboratories. Likewise the plasma pooling and storage flasks are prepared aseptically by the same concern. Hemoglobin determinations are made prior to the withdrawing of blood, and all donors with a hemoglobin of below 10 grams are rejected. Hintons, typing and Rh factors are done on each blood as a routine procedure. These bloods are stored and used as whole blood for not longer than five days. On the sixth day the plasma is removed, and several specimens are pooled. We have had no experience with preserved blood and do not anticipate such a move in the future as long as fresh blood can be made available. The plasma is allowed to remain in the pooling flasks for eight to ten days and then transferred to the smaller "unit" flasks, each containing 250 cc. These pooled flasks of plasma each have a total protein determination made and recorded on each "unit" flask. A hemoglobin determination is made on each pooled specimen of plasma and rejected if it contains more than .75 grams. If all of the required tests are satisfactory the unit flasks are placed in a freezing unit and stored indefinitely. They are available at a moment notice, and can be thawed out and started into the veins of the patient within 20 to 25 minutes from the time ordered.

The mystery which has for many years been associated with the performing of a blood transfusion is very rapidly being dispelled by the ever increasing knowledge of the fundamentals of physiology so necessary for the practice of sound medicine and surgery. The progress of the war has accelerated research and relegated the transfusion of blood into the category of essential rather than heroic therapeutics. The discovery of the Rh factor by Landsteiner and Weiner in 1940 has added the most important milestone to the safety of the procedure since 1900. The determination of the Rh factor in the donor and the recipient should be as much a routine procedure as the blood typing itself. The agglutinogins A B and Rh are constant factors in red blood cells, and each deserves an equal observation before every transfusion.

The designation of the types of blood have for the past generation been accepted by the medical profession as falling into one of four main groups, designated by the League of Nations as O, A, B, or AB, with type O being the so-called universal donor of the International Nomenclature. Other methods of classification should now be only of academic interest, as attempts at comparison only serve as a means of confusing the doctor who gives an occasional transfusion. The more infrequent agglutinogens A2, A3, M, N, and P could be used as a means of designating many other types of blood. It is very reasonable to assume that with blood transfusion increasing at its present rate other new factors will be discovered which may in the generations to come set up a heterogenous mass of agglutinogens in which heredity will prove a strong influence. For the present, however we are content to make the transfusion of blood as simple as possible. The universal donor has been given a rating during the past thirty-five years that may well react in a similar manner. The fact that a type O blood contains both alpha and beta agglutins must be given more attention. I am of the opinion that all blood transfusions should be confined to the same groups, except in cases of emergency that cannot be reasonably and safely treated with blood plasma. Such an emergency is becoming more and more difficult to find and the transfusion experience in the war will surely startle the medical minds that have been reluctant to accept plasma.

Conclusions

1. The functioning of a blood bank in a small hospital is described in detail.

2. Experience with over two thousand transfusions has been recorded.

3. A new method of obtaining donors has been outlined.

4. A few observations by the author are recorded as a means of further reducing transfusion reactions.

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AN INTERNE LEARNS OF PENICILLIN

CALVIN M. GORDON, M.D.

The Author, *Calvin M. Gordon, M.D., Rhode Island Hospital.*

(The following resumé of a talk on "Clinical Experience with Penicillin" given by Donald G. Anderson, M.D., research fellow in medicine at Evans Memorial Hospital, Boston, before the Providence Medical Association on April 3, 1944, was written by Calvin M. Gordon, M.D., and it is commended to the membership as an excellent piece of medical reporting by one of our internes—THE EDITORS.)

AT THE April meeting of the Providence Medical Association an extremely interesting discussion of the yet scarce drug penicillin was presented in the Library of the Rhode Island Medical Society. The program, which occupied the greater part of the evening, was shared equally by Dr. Anderson, of the Evans Memorial Hospital and by a dozen, more or less, representatives of the four hospitals in this city to which penicillin has been allotted.

Dr. Anderson in his brief talk gave a resume of the development of penicillin from its accidental discovery by Dr. A. Fleming in 1929 up to the widespread studies that have been going on, both in civilian and military life, during the past two to three years.

Most of his time, however, was spent in describing, in some detail, the results of experiments carried on by Dr. Keefer and himself at the Evans Memorial Hospital in connection with the National Research Council. Comment was made on the effectiveness of the drug, the dosage, excretion, blood level, toxic reactions and methods of administration, all of these being made very clear by the excellent lantern slides accompanying his talk.

Much work has been done on the various modes of administration, the dosage required and the subsequent excretion of the drug. In discussing this he emphasized the fact that the various infections must be subdivided to include in one category those which affect a serious space, such as the joints, empyema cavity, subdural space, etc., into which penicillin does not seem to penetrate, in contrast to a more generalized infection such as pneumonia, bacteremia and similar conditions. Speaking of these methods, he emphasized the uselessness of oral administration due to the inactivation of the drug by the gastric juice.

Evidence seems to have been accumulated that in the former, direct local application of the drug must be made to obtain the desired results. Just as the drug does not seem to penetrate from the blood stream to these spaces, so it does not seem to be absorbed rapidly. Levels taken at various intervals following the topical administration show the rate of decline to be extremely slow with a concentration effective against most organisms being maintained for 20-24 hours. Doses of 10-20 thousand units, once or twice a day, placed directly in the affected joint or cavity would then seem to be sufficient to defeat or at least localize the disease process.

In contrast to this method of treatment however, the administration of the drug in generalized systemic disease must be directed toward administering a dose, large enough to cause an effective blood level, often enough to maintain this level. For this three different methods have been tried with the formulation of a rather definite plan of therapy.

Methods of Administration

In the first place, it might be well to speak of and dispense with a method which, although effective, has some drawbacks, namely the subcutaneous route. Using this method it was found that a rather low level was obtained but was maintained over a considerable period of time. Although this sounds to be a feasible method of administering penicillin it has the main drawback of being extremely irritating.

Repeated intravenous administration, on the other hand, was found to produce an optimal level in the blood stream a few minutes after each injection with a subsequent sharp decline in the concentration of the drug. Studies instituted at this time revealed that after 15 minutes approximately 75% of the drug had been excreted and that after 30 minutes almost 90% had left the blood stream.

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CROOKED TEETH

DONALD D. OSBORN, D.M.D.

NORMAL occlusion is a state of balance and harmony of the teeth, jaws and surrounding tissues and parts. Under favorable conditions of growth, development and inheritance these parts often combine in such a manner that, as a unit, they present a pleasing symmetry of beauty and form. In such instances we are deeply impressed by such a harmonious relationship for it is that part of us which meets "the world's eye" and determines to a very great extent the kind of treatment accorded us throughout life.

All of us are endowed at birth with certain basic physical and mental qualities which determine the degree of growth, development and physical perfection that our bodies will attain during life. Yet, this normal process is continually subjected to a great many external and internal forces which influence and modify the naturally endowed body pattern. Sometimes these changes may be beneficial to the growing child, but more often than not they are harmful and produce disturbances in the form and relationship of the underlying structures including those of the face, resulting in facial malformations and inharmonies.

Physicians, dentists and other scientific investigators have studied the development and growth of the face and jaws, recording their observations, so that medical and dental care of the people may be placed on a rational basis. It has been estimated that the face of an infant is 42 per cent of its ultimate size; while a larger part of the facial growth takes place in the region of the mouth and jaws, particularly during those periods when the deciduous teeth, and later the permanent ones, appear.

Factors in Face and Jaw Development

Observation and study of this growth have shown that numerous factors seriously affect the normal development of the face and jaws. Many of the causes are not fully understood, perhaps because of their complexity, but critical study of them has shown that early loss of teeth through neglect and decay; pernicious habits during infancy such as thumb and finger sucking; congenital defects including enlarged tongue, missing teeth, hare lip and cleft palate; and accidents involving destruction or mechanical injury of the parts are potent factors in producing them. Occasionally, endocrine disturbances are revealed through dental anomalies so the services of a medical specialist are needed.

Within the present century, the orthodontist has developed diverse means of combating the many dental and facial deformities that occur. The dentists who specialize in this field of practice are practically unanimously agreed that early periodic observation and care of children's teeth is the safest way of preventing deformities. Advice should be sought, when the twenty deciduous teeth have fully erupted, from a competent dentist. Even at this early age extreme deformities are recognizable, while the orthodontist can decide the advisability of their immediate or later treatment. As a general rule the greatest percentage of children who need corrective treatment should have orthodontic treatment instituted by the ninth year or when the four upper and lower incisors have erupted.

In the past, when a child showed abnormal dental development, it was generally believed nature should take its course and the child would, perhaps, outgrow the deformity. Today, investigations have shown conclusively that this belief is usually wrong; for only, in rare instances, does a dental deformity correct itself. Such rarity does not warrant observing a case without orthodontic intervention until the child is too old for the best results possible. It is much more advisable to seek the counsel of a specialist in deciding whether treatment is, or is not, indicated.

Psychological Reactions

One of the greatest handicaps in childhood, as well as in adult life, is to be different than one's fellows. While we in America believe in freedom, we also demand conformity. Upon analysis, we discover that certain costumes, habits, and fads become popular only because of our tendency to conform to the demands of current opinion; while those who are different must be prepared to suffer the consequences. Likewise the child whose facial appearance is different from the normal will tend

to withdraw from his playmates. He becomes moody and his physical as well as mental well being suffers. Also in the critical period of adolescence, with its maturing influences of companionship, dental deformities frequently are a grave barrier. If tolerated without correction, this state of affairs may cause certain psychological reactions disturbing to one's mental security. It creates unfavorable complexes of inferiority which may seriously affect or perhaps ruin an entire career. While there are persons who were deformed or whose faces were, to say the least, unattractive but who were, nevertheless, very successful in life, in almost every case we find that these persons were possessed of great talent. They were bound to succeed in spite of all handicaps. In any event, their poor facial appearance certainly was no asset to them.

Although the appearance is an important factor, other benefits are derived from a normal relationship of the teeth and jaws. They provide the efficient grinding and preparation of food before it is swallowed. Any position of the teeth which impairs mastication strikes directly at normal digestion and places an added burden on other organs to carry, which are sooner or later liable to revolt because of being overburdened, and fail in their own functions.

Normal occlusion helps preserve the teeth against the increased probability of decay and prevents the development of diseases of the soft tissues surrounding the tooth roots. When not in their correct positions, the teeth may suffer the erosive effects of disuse or the wear and tear of over-use with a final breaking down of the entire dental organ.

And so it can be seen that a state of balance and harmony of the teeth, jaws and surrounding tissues and parts results in a healthy mouth which protects one of the most vulnerable parts of the human body against numerous inroads of disease and fosters health and usefulness.

BLOOD TRANSFUSION AND BLOOD BANK

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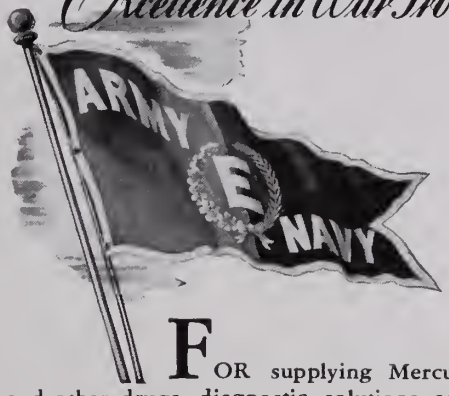
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CHARLES V. CHAPIN ORATION

The action of the Providence City Council in adopting an ordinance within the past month to create a standing committee to cooperate with the Rhode Island Medical Society in perpetuating the memory of Dr. Charles V. Chapin, superintendent of health in Providence for 48 years, and honored all over the world as the foremost city health officer of all, is singularly appropriate.

For his life-time of labor in the field of medicine Dr. Chapin received citations and awards such as are given to few men in their respective fields. In his 48 years of service as Superintendent of Health in Providence he revolutionized long accepted theories of sanitation to appreciably reduce the dangers of communicable disease. Through his efforts the City of Providence became known throughout the world for its progressive work in health, for during his administration the first municipal laboratory in the country was established, the first experiments in filtering water by mechanical filtration were made, and the City became the first city to discontinue fumigation as a form of terminal disinfection in the prophylaxis of contagious disease, a step that subsequently won public praise from the hygiene section of the League of Nations at Geneva.

In tribute to his numerous contribtuions to the science of medicine and particularly his service to his native city and the City Hospital, the name of that institution was changed to the Charles V. Chapin Hospital in 1932 by recommendation of the board of hospital commissions and with the unanimous recommendation of the City Council. Now the last named body has again contributed willingly to the plan of the Rhode Island Medical Society to perpetuate Dr. Chapin's name throughout the country by means of the annual oration given as part of the annual program of the Society. Started two years ago with the oration by Dr. Timothy Leary, professor of pathology at Tufts College, and continued last year with the outstanding oration on "Contagious Diseases" by Dr. Edwin H. Place, the Chapin oration takes on new significance this year, and in the years ahead.

In perpetuating the name of Chapin the Society adds further lustre to the great achievements of the doctors of medicine of this State, and the City of Providence keeps alive throughout the nation the knowledge of its progressiveness in the field of public health.

PRESCRIBING LUXURIES

It's harping on an old story. Do they need more gas or tires for transportation, more heat in their house, more red meat? Have their physician write them a prescription.

Frequently we can persuade ourselves that these needs are genuine. But how often have we really believed that a patient needed 40% cream? If we like a sturdy cup of morning coffee, chewy cream certainly does not thin it. For dainty desserts the heavy cream whips up the best, we believe. However, these are luxuries, not therapeutic needs. The council on Foods and Nutrition says that only in a ketogenic diet is heavy cream necessary and the ketogenic diet is necessary practically only in epilepsy, and this can be attained by the use of butter, etc. So apparently there is infinitesimal chance of hardship if no longer are prescriptions written for the heavy cream.

It has been stated that half a million quarts of milk daily are going into heavy cream on doctor's prescriptions in New York City. The owner of a herd in this state giving milk of the heaviest cream content says that it takes about 10 quarts to produce one quart of 40% cream. It might require as high as 14 quarts from some herds. So the wastage is terrific especially in this section where the uses of skim milk are presumably restricted.

It was a wise person who said, "Let me have the luxuries of life and I can get along without the necessities." But it is being repeatedly demonstrated even in this calm overpaid section of the globe that the opposite is true although an unpleasant truth.

The medical profession should cooperate to keep down the use of heavy cream, and if the responsibility is largely lifted from our shoulders by more stringent regulations we will presumably welcome that very minor interference with the rights of the individual.

COSTLY "REHABILITATION"

A year ago last month the General Assembly enacted legislation to provide for the establishment of a special curative centre for the rendering of physical therapy, psychotherapy and occupational therapy for beneficiaries under the workmen's compensation act who might require such services.

In the year that has elapsed approximately fifty thousand dollars has been paid into the fund by insurance companies and self-insurers. With the money thus acquired the State, through the Department of Labor, has acquired a large East Side estate as the structure to house the centre.

In twelve months' time the advisory board has not been named by the director of labor. No medical director has been appointed, nor for that matter any other personnel. No one has been treated at the "centre", and apparently no one will be treated for some time to come if present indications are any barometer of progress.

Meanwhile the collection of funds will continue, but not at the expense of the insurance companies. They revised their rates, as of April, 1943, thus passing the bulk of the expense for the centre back on industry, which in turn is in a position to pro rate the cost down to the individual who was to be so greatly benefited, at no expense to himself, by the centre.

And while the Labor Department invested in real estate, Rhode Island hospital, a private agency, gave over 25,000 treatments to 903 patients through its physical therapy department, and nearly 5,000 treatments to 251 patients referred to its occupational therapy division, and the Bureau for the Handicapped, a voluntary agency in Providence, rendered occupational therapy to more than 300 patients. How many of all these patients, if any, might have been treated at the State curative centre is not known, but it is reasonable to assume that some of them might have been referred there.

In a day when proponents of social security are advocating the administration of health programs by federal and state governments the curative center development offers a fine illustration of what the public may expect. Careful, progressive planning gives way to costly operations which indicate future costly administrative outlays, with the burden of expense rapidly shifted to the worker who in turn must speculate on when and how he is to be benefited under the program.

PROPER DIET AND TEETH

Food rationing has probably done far more to focus attention upon nutrition and its allied problems than any educational program could do in years of effort. It is appropriate, therefore, that dentistry take a more active interest in the entire field of nutrition, and in so far as possible participate in the development of programs having such an important bearing on preventive dentistry.

A report released recently by the medical department of a national life insurance company relates that 9 out of 10 American children have one or more decayed teeth by the time they reach the age of six years. Between the ages of six and eighteen, those

continued on next page

who made the study report, the average American child develops one additional decayed tooth each year.

However, proper food with severely limited sweets, or scientifically administered supplementary vitamins and minerals where diet is bad, and enough but not too much of the chemical element fluorine, have all been shown in various experiments with hundreds of children to reduce tooth decay. Diets containing whole grain breads and cereals, adequate meats, vegetables and fruits, sufficient milk, and cod liver oil have been tested in various medically supervised experiments covering two or more years. Compared with children in other groups eating the average American diet with its load of refined starches and sweets, and mushy foods that require little chewing, the contrast has been striking, with the reduction in tooth decay as high as 80% or more in some of the experiments.

CARE OF THE TUBERCULOUS VETERAN

Dr. Louis I. Dublin's remarks at the recent annual luncheon of the Rhode Island Tuberculosis Association deserve more widespread comment than they have received. We must stop and ponder about 10,000 veterans of the last war being admitted and discharged each year from the Veterans' Tuberculosis Hospitals. We must be gravely concerned with the inability of the Veterans' Hospitals to administer their tuberculosis program more successfully. His advice to health authorities to focus attention upon the ineptitude in the past and to attempt to establish a better exchange of information with the Veterans' Administration is sound and welcome.

The numbers of discharged Veterans suffering from pulmonary tuberculosis poses a problem which transcends the lofty ideals of our legislators in their zeal to secure benefits for the men and women in service. It is commendable that sincere efforts are being directed toward making the return of the serviceman a happy one. We know that the people at home will be waiting to help the millions who will return sound in mind and body; we must depend upon them to aid these veterans in returning to a normal way of living. Our sympathies go out to all servicemen. Practical thinking, however, should lead us to give graver consideration to those who will return with their health impaired.

There is no doubt in the minds of many public health authorities that the number of tuberculosis veterans of the present conflict will exceed that of the First World War. We know that the severe conditions which many of these service men and women will have to endure will tax the reserve of their healthy bodies. The enervating heat of the tropics, the oppressing cold of the northern zones, the sleepless nights, the damp foxholes,—all will surely cause some of the primary infections to undergo decalcification with a resultant spread of the tuberculosis in the exhausted body. The high physical standards so judiciously set up by Selective Service will serve to keep the incidence of tuberculosis at the lowest possible level. However, the scope and duration of the war, together with the large numbers of American youth engaged, will inevitably make tuberculosis a definite major problem distinct from other service connected disabilities.

This is an all-important factor in the cure of tuberculosis. It is conceivable that many of the veterans will find it more convenient to receive treatment by and through their local health authorities. The veterans' facilities will be so burdened with traumatic disabilities that tuberculosis with its long course may not be able to find retreat in them. The local tuberculosis authorities are ever ready to aid the veteran in receiving his treatment wherever he finds it to his advantage. It is not enough for the Veterans' Administration to make the information available on request. It is highly probable that in a large percentage of cases many months will have elapsed before the local authorities become acquainted with the diagnosis. The obligation of the Veterans' Administration, in tuberculosis at least, goes beyond making records available. Clerical red tape in tuberculosis will cost the government billions of dollars, and possibly many lives, and surely many months of good health to the tuberculosis veteran. It would be a high tribute to the efficiency of the Veterans' Administration if it would formulate some method to furnish the local health authorities with the diagnosis as soon as the disease is discovered.

A solution to many problems might be found if the government would set up a post-discharge examination center conducted by private medical men much the same as the pre-induction centers which are operating so creditably. Such a post-exchange board of examiners could serve a double function of classifying the individual as to the type of disability and forwarding his problem to the particular local agency which is interested in his rehabilitation.

RHODE ISLAND STATE DENTAL SOCIETY

ARTHUR M. DRING, D.M.D., *President*
EARL B. KEIGHLEY, D.M.D., *President-Elect*
WILLIAM S. GEE, D.M.D., *Vice President*
CHARLES F. MCKIVERGAN, D.M.D., *Secretary*
JAMES C. KRASNOFF, D.M.D., *Treasurer*
HAROLD F. DOYLE, D.M.D., *Librarian-Curator*
NORMAN H. FORTIER, D.M.D., *Editor*

TESTIMONIAL TO DR. A. L. MIDGLEY

On April 19 members of the Society, together with a host of friends including outstanding leaders in the civic, professional and business life of the State, tendered a testimonial dinner to Dr. Albert L. Midgley of Providence in honor of his 35 years of continuous service on the R. I. Board of Examiners in Dentistry, and for his many notable contributions to the advancement of the profession. The testimonial was sponsored by the board of dental examiners.

Characterized as one of the greatest contributors to the forward progress of dentistry during the past three decades by Dr. William J. Gies, Dr. Midgley was lauded also by Governor J. Howard McGrath, Acting Mayor of Providence William A. Cahir, Dr. Arthur M. Dring, president of the Society, Dr. Edward A. McLaughlin, state director of health, Dr. Ambrose Lynch, who also brought the greetings of the Elks, John J. Crimmings, and Dr. Basil G. Biby, dean of Tufts College Dental School.

The program was highlighted further by the presentation of a framed testimonial to Dr. Midgley by Dr. Ernest A. Charbonnel, director of the Joseph Samuels Dental Clinic for Children, in behalf of the Society and the Board of Examiners in Dentistry.

SHORTAGE OF HYGIENISTS

In these days of extra effort there is an increased need for dental hygienists. The opportunity of relegating prophylactic work to the hygienist enables the dentist to give many more of his valuable hours to satisfy the public need for dental attention, either palliative or reconstructive.

The officers of the Society are interested in the possibility of a survey of the State to determine the need for hygienists on the basis of the possibility of dentists employing such personnel. Therefore members are urged to write to the Secretary, at 102 Waterman street, Providence, stating whether or not they would hire a hygienist permanently if such trained assistants were available. On the basis of such information the officers would be in a position to formulate some program for publicizing the need and would also be in a position to develop a plan to encourage high school graduates to consider careers as dental hygienists.

FROM THE SECRETARY'S DESK

Dr. Edward C. Morin, chairman of the Horace Wells Centennial Committee, has announced the appointment of Dr. Walter F. Tompkins of Providence and Dr. James F. Colgan of Pawtucket to serve as members of the committee.

Dr. Fred H. Dotolo, of Westerly, was recently installed as Exalted Ruler of Westerly Lodge of Elks, succeeding William Donovan.

Captain Sarkis Shagalian, DC, of Cranston, called to active duty three years ago, was home recently on furlough from his post in Greenland.



At the testimonial dinner to DR. ALBERT L. MIDGLEY in honor of his 35 years of continuous service on the Rhode Island Board of Examiners in Dentistry.

Seated — Hon. J. Howard McGrath, Governor of Rhode Island; Dr. Midgley.

Standing (l. to r.) — Hon. William A. Cahir, Acting Mayor of Providence; Dr. William J. Gies, Professor of Biochemistry, Columbia University, College of Physicians and Surgeons; and Dr. Ernest A. Charbonnel, director, Joseph Samuels Dental Clinic for Children.



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6 level packed tablespoonfuls equal 1 ounce

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PROCUREMENT AND ASSIGNMENT SERVICE FOR NURSES

MILDRED L. HATTON, R.N.

The Author. *Mrs. Mildred L. Hatton, R.N., Assistant Director, Providence District Nursing Association; Chairman, State Procurement and Assignment Committee for Nurses.*

IN order to meet the military needs for nurses and to adequately protect the health of the civilian population, a Procurement and Assignment Service for Nurses under the War Manpower Commission has been set up in the state of Rhode Island as well as in every other state in the Union.

This group has been directed by the War Manpower Commission in Washington to make a study of the nursing needs and resources of the state in an effort to determine *which* nurses in *which* positions in *which* agencies are essential. The armed forces have a priority right on nurses; the remaining nurses must be equitably divided among the non-military governmental agencies and *essential* civilian nursing services. A fair distribution can only be accomplished by a withdrawal of nurses for military service on a selective basis and the best use of the remaining nurses where they are most needed. Resources for meeting civilian needs not only include nurses now actively employed but also inactive nurses, nurses working in non-nursing positions, student nurses, nurses' aides, other volunteers, and paid auxiliary workers.

An effort is being made to have every nurse serve in the position where she is most needed and where her abilities may be used to the fullest. Every nurse is given a *classification* made on the basis of her age and her family situation, as well as on the position which she holds. If a nurse is in Class I, she is available for military service; In Class II, she is available for relocation; In Class III, she is essential for a limited duration or until replaced; In Class IV, she is essential for an unlimited duration.

To help facilitate the important work of supplying and distributing nurses, the State Committee on Procurement and Assignment has appointed subcommittees to work in the local areas. These Local Committees have full responsibility for classifying all nurses within their areas and they also are consultant bodies, empowered to listen to all the problems concerning nursing service in the area. After a nurse has been classified by the Local Committee, a report is sent to the State Committee for final approval. In a situation where the nurse or the employer does not approve of the classification, either the nurse or the employer or both may appeal to, or appear before, the State Committee involved for a rehearing of the factors.

Nurses are subject to the same provisions of the employment stabilization program which applies to other workers in other essential activities, and they may not change their positions without securing statements of availability from the local United States Employment Service. No nurse should be employed without this statement of availability.

Any doctor having a problem relative to the availability of nurses for civilian or for war service should communicate with the chairman of the local committee in his area. These chairmen are as follows: Newport area—Mrs. Mary Noonan, 98 Champlin Place, North, Newport; Pawtucket area—Mrs. T. Edward Aldham, 149 Center Street; Rumford; Providence area—Mrs. Elvera Richardson, 192 Angell Street, Providence; Warwick area—Miss Florence L. Tanner, 30 Rolfe Street, Cranston; Westerly area—Miss Ethel Angilly, R.F.D. No. 71, Saunderstown; Woonsocket area — Mrs. Alice Lamoureux, 36 Manville Road, Cumberland Hill.

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DISTRICT SOCIETY MEETINGS

THE WASHINGTON COUNTY MEDICAL SOCIETY

The regular meeting of the Washington County Medical Society was held April 12th at the Elm Tree Inn, Westerly. After a short business meeting Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society, gave an interesting talk on some phases of Health Security in Rhode Island.

He discussed problems which face the medical profession and explained how the Rhode Island Medical Society is endeavoring to meet some of these issues.

At the close of the meeting luncheon was served.

JULIANNA R. TATUM, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was held at Memorial hospital on April 20. In the absence of President Edward H. Trainor, Dr. Joseph Doll presided.

After a discussion of the development of the Association's radio program with utilization of material available through the executive office of the State Society, Dr. Charles L. Farrell discussed briefly the scope of the industrial health program, and also commented on what the Providence Chamber of Commerce is doing in regard to the development of industrial health activities.

MARY E. J. ROHR, M.D.

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, April 3, 1944.

The President reported that the committee of Dr. Louis I. Kramer and Dr. Ezra Sharp had submitted the Association's tribute to the late Dr. Irving Blazar and that it had been placed on permanent file with the records of the Association.

The Secretary reported that the Executive Committee recommended for election to membership in the Association Dr. Walter E. Batchelder now in service with the armed forces. On the motion of Dr. Jesse E. Mowry, Dr. Batchelder was unanimously elected to active membership.

The President introduced as the guest speaker of the evening Dr. Donald C. Anderson, Research Fellow in Medicine, Evans Memorial Hospital and Instructor in Medicine, Boston University School of Medicine who spoke on the topic "Clinical Experience with Penicillin".

Dr. Anderson made interesting comments on these cases. The opportunity for our membership to obtain first-hand information on this new and wonderful drug was greatly appreciated.

The meeting adjourned at 11:45 P. M.

Collation was served.

Attendance 105.

Respectfully submitted,

FRANK W. DIMMITT, M.D., *Secretary*



EDWARD H. TRAINOR, M.D.

President of the Pawtucket Medical Association—1944

Program - - 133rd Annual Meeting

RHODE ISLAND MEDICAL SOCIETY

May 24-25, 1944 *R. I. Medical Library, Providence*

WEDNESDAY, MAY 24

At R. I. Medical Library, Providence

2:15 P.M. CALL TO ORDER
WELCOME BY PRESIDENT, Michael H. Sullivan, M. D.
RECOGNITION OF DELEGATES from other State Medical Societies

2:30 P.M. "VIRUS INFECTIONS"
Paul C. Cook, M. D. of Providence

2:50 P.M. "RESULTS IN TREATMENT OF 60 CASES OF MALARIA, AND A REVIEW OF 100 CASES OF FILARIASIS"
Comdr. Clarence C. Fuller, MC, USNR, of Newport Naval Hospital

3:20 P.M. INTERMISSION TO VISIT EXHIBITS

3:40 P.M. "PLANNING FOR MEDICAL CARE"
James R. Miller, M. D. of Hartford

4:15 P.M. "SICK HEADACHES"
Walter C. Alvarez, M. D. of Mayo Clinic, Rochester, Minnesota



Walter C. Alvarez, M.D.

5:30 P.M. SOCIAL HOUR AT BILTMORE HOTEL—

* * * * *



Reginald Fitz, M.D.

9:00 P.M. At the Medical Library
The Charles V. Chapin Oration
"FORECAST BY NUMBERS"
Reginald Fitz, M. D. of Boston

THURSDAY, MAY 25

At Peters House Auditorium, Rhode Island Hospital

10:30 A.M. PRESENTATIONS FROM STAFFS OF HOSPITALS OF RHODE ISLAND

B. EARL CLARKE, M.D., *Chairman*

10:30 Charles V. Chapin Hospital
Edward J. West, M.D.
"Toxic Manifestations of Sulfa Drugs"

10:40 State Hospital for Mental Diseases
John F. Regan, M.D.
"The Development of the State Hospital for Mental Diseases"

10:50 Pawtucket Memorial Hospital
Henry B. Moor, M.D.
"Indications for and Methods of Skin Graft"

11:00 South County Hospital
Samuel Nathans, M.D.
"Caudal Anesthesia"

11:10 St. Joseph's Hospital
Vincent J. Oddo, M.D.
"A Rare Case of Suppression of Urine"

11:20 Emma Pendleton Bradley Home
Charles Bradley, M.D.
"Modifying the Behavior of Convulsive Children"

11:30 Lying-In Hospital
Maurice Adelman, M. D.
"Report of a Case of Erythroblastosis in One of Twins"

11:40 Woonsocket Hospital
Francis J. King, M.D.
"Surgery After the Seventh Decade"

11:50 Homeopathic Hospital
E. Victor Conrad, M.D.
"The Pre and Post Operative Treatment of Neoplastic Obstruction of the Colon"

12:00 Newport Hospital
Samuel Adelson, M.D.
"Appendicitis Complicating Measles"

12:10 Rhode Island Hospital
Alex M. Burgess, M.D.
"Recent Experience With Pneumonia"

12:20 Butler Hospital
Arthur H. Ruggles, M.D.
"The Development of Medical Work at Butler Hospital Over a Period of One Hundred Years"

1:00 P.M. LUNCHEON AT HOSPITAL

* * * * *

At the Rhode Island Medical Library

2:00 P.M. "COMBAT SURGERY IN THE PACIFIC AREA, WITH A DISCUSSION OF BRAIN INJURIES"

Lt. Comdr. Hannibal Hamlin, MC, USNR, of Newport Naval Hospital

2:30 P.M. "DIAGNOSTIC AND THERAPEUTIC CONSIDERATIONS IN ANTERIOR POLIOMYELITIS"

William T. Green, M. D. of Boston



William T. Green, M.D.

3:00 P.M.



Richard B. Cattell, M.D.

"PROGRESS IN THE SURGERY OF THE GALL BLADDER AND THE BILE DUCT"

Richard B. Cattell, M. D. of Lahey Clinic, Boston

3:30 P.M. INTERMISSION TO VISIT EXHIBITS

3:45 P.M. "MALARIA", J. B. Rice, M. D. of New York City

4:30 P.M. PRESIDENTIAL ADDRESS
Michael H. Sullivan, M. D. of Newport

5:00 P.M. INSTALLATION OF NEW OFFICERS



J. B. Rice, M.D.

Program - - First Annual Meeting

RHODE ISLAND SOCIETY OF INDUSTRIAL PHYSICIANS AND SURGEONS, INC.

and the

RHODE ISLAND INDUSTRIAL NURSES' CLUB, INC.

Rhode Island Section Meeting of the New England Conference of Industrial Physicians and the New England Industrial Nurses' Association

TUESDAY, MAY 23

At the Rhode Island Medical Library

10:00 A.M. Greetings:

Charles L. Farrell, M. D., President, R. I. Society of Industrial Physicians and Surgeons

Helena C. Mahoney, R.N., President, R. I. Industrial Nurses' Club

10:10 A.M. "CHILD LABOR DURING WAR TIME"

Beatrice McConnell, Director, Industrial Division, Children's Bureau, U. S. Dept. of Labor

10:30 A.M. "R. I. CASH SICKNESS BENEFIT, REPORT OF FIRST YEAR OF OPERATION"

Mortimer W. Newton, Chairman, R. I. Unemployment Compensation Board

10:50 A.M. Subject to be Announced

Daniel L. Lynch, M. D., Medical Director, New England Telephone and Telegraph Company, Boston; President, N. E. Conference of Industrial Physicians

11:10 A.M. "INDUSTRIAL OPHTHALMOLOGY"

Speaker to be Announced

11:30 A.M. "HOSPITALIZATION AND CASH SICKNESS INSURANCE SPONSORED BY INDUSTRY"

Orlen J. Johnson, M. D., Council on Industrial Health, American Medical Association

12:00 Noon RECESS FOR LUNCH

1:00 P.M. "OCCUPATIONAL DERMATOSES IN RHODE ISLAND INDUSTRIES"

Louis Schwartz, Medical Director, U. S. Public Health Service; Chief, Dermatoses Section, Division of Industrial Hygiene

2:30 P.M. "THE MEANING OF INDUSTRIAL MEDICINE, HYGIENE, and HEALTH"

C. O. Sappington, M. D., Dr. P. H., Editor, *Industrial Health*

3:10 P.M. "TRENDS IN INDUSTRIAL NURSING"

Catherine Dempsey, R.N., President, American Association of Industrial Nurses

3:30 P.M. Symposium:

"RECONDITIONING OF DISABLED WAR VETERANS AND THEIR ASSIMILATION BY INDUSTRY"

Arranged by Office of the Surgeon, Armed Service Forces, First Service Command

8:30 P.M. Annual Business Meeting

R. I. Society of Industrial Physicians and Surgeons and R. I. Industrial Nurses' Club

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EXHIBITORS AT THE

133rd Annual Meeting of the Rhode Island Medical Society

and at the

1st Annual Meeting of the Rhode Island Society of Industrial Physicians and Surgeons, and the Rhode Island Industrial Nurses' Club

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22	Owens-Corning Fiberglas Corp.
24	Brewer & Company, Inc.
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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

DOCTORS AT WAR

ALONG THE LEDO ROAD

A feature story by an Associated Press writer recently reported the work of some of the 48th Hospital Unit somewhere along the Ledo road which American GIs are carving through the Burma jungle. The account listed in detail many of the difficulties the Rhode Island doctors are facing in that area. With the Burma invasion in full swing Rhode Islanders have a deep interest in the battles now ranging in that theater of operations, and the reports of possible severance of the railroad north of Imphal, which would presumably cut off the supplies to the men, except by air transport, cause no little concern. There is reason to believe that the Unit is probably on detached service by now, working as small groups attached to various military formations strengthening the route to China.

AWAITING THE WESTERN INVASION

We continue to hear from our doctors in England, and apparently all of them are keenly aware of the struggle ahead, and of the work which faces them. One of the latest to report is MAJOR SIMON ALBERT, MC, who spent his first year of overseas service in the northern stretches of Iceland, just below the Arctic Circle. Dr. Albert's unit is reported to be enjoying an enviable reputation among the station hospitals, and it has been engaged in the care of battle casualties.

CAPTAIN VINCENT A. BIANCHINI, MC, who has been in the British Isles for a year and a half, reports that he has been working with colleague from Rhode Island, MAJOR ANACLETO BERRILLO, MC. A more recent arrival in that area is CAPTAIN WILLIAM HINDLE, MC, son of the superintendent of the C. V. Chapin Hospital. Captain Hindle completed a course of lectures under Dr. Watson Jones in London in January, and then returned to active duty with his station hospital.

ON THE PACIFIC ISLANDS

After taking part in the Marshall Islands invasion LIEUT. NICHOLAS POURNARAS, MC, USNR, former Block Island physician, was reported enjoying a well earned rest at Hawaii. From the New Guinea area have come messages from CAPTAIN MORRIS BOTVIN, MC, MAJOR DAVID LITCHMAN, MC, who is chief of medical service with his hospital unit, and CAPTAIN MARK A. YESSIAN, MC, who reports that he is receiving our *Journal* and is deriving much pleasure from reading of the activities of the Society and of the other doctors who are stationed on the many war fronts.

Our last reports from Lt. Col. Harold Rogell, MC, commanding officer of a station hospital, placed him among one of the most forward units in combat in the New Guinea area.

ACROSS THE NATION

CAPTAIN PHILIP S. GELLER, MC, reporting from Dibble General hospital in Menlo Park, California, where he is chief of the septic surgery section, calls our attention to the fact that he has been promoted to the rank of Captain. Dr. Geller has completed an 18 month tour of duty in Iceland.... CAPTAIN EMIL A. KASKIW, MC, of Woonsocket, is now stationed at Camp Ellis in Illinois.... LIEUT. MAURICE N. KAY, MC, has been transferred from the 114th to the 54th Station Hospital but he is still stationed at Fort Bragg.... MAJOR MORRIS L. GROVER, MC, sends us words of appreciation for the many courtesies extended to our doctors in Service, and also reports enthusiastically on the *Journal*....

continued on page 239

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AN INTERNE LEARNS OF PENICILLIN

continued from page 219

Convincing proof that this excretion was carried out by the kidney was offered in comparing two series of cases, one of which had normal functioning of kidneys while the other group was plagued with one or more kinds of kidney pathology. Invariably the patients with the diseased kidney would maintain an effective concentration considerably longer than their more healthy compatriots. The obvious inefficiency of this repeated intravenous injection was easily overcome in a short time by instituting a continuous drip of penicillin in saline or glucose at such a rate that the patient was receiving about 5000 units per hour. Using this method it was felt that the optimal concentration could be maintained for the greatest period of time.

The third and probably most widely used method as set forth by Dr. Anderson consisted of repeated intramuscular injections of 10-15 thousand units every three hours. This method produces a rapid rise in blood concentration which reaches a maximum in 15 to 20 minutes, remains more or less stationary for about one-half hour and then gradually falls off until a trace can be detected.

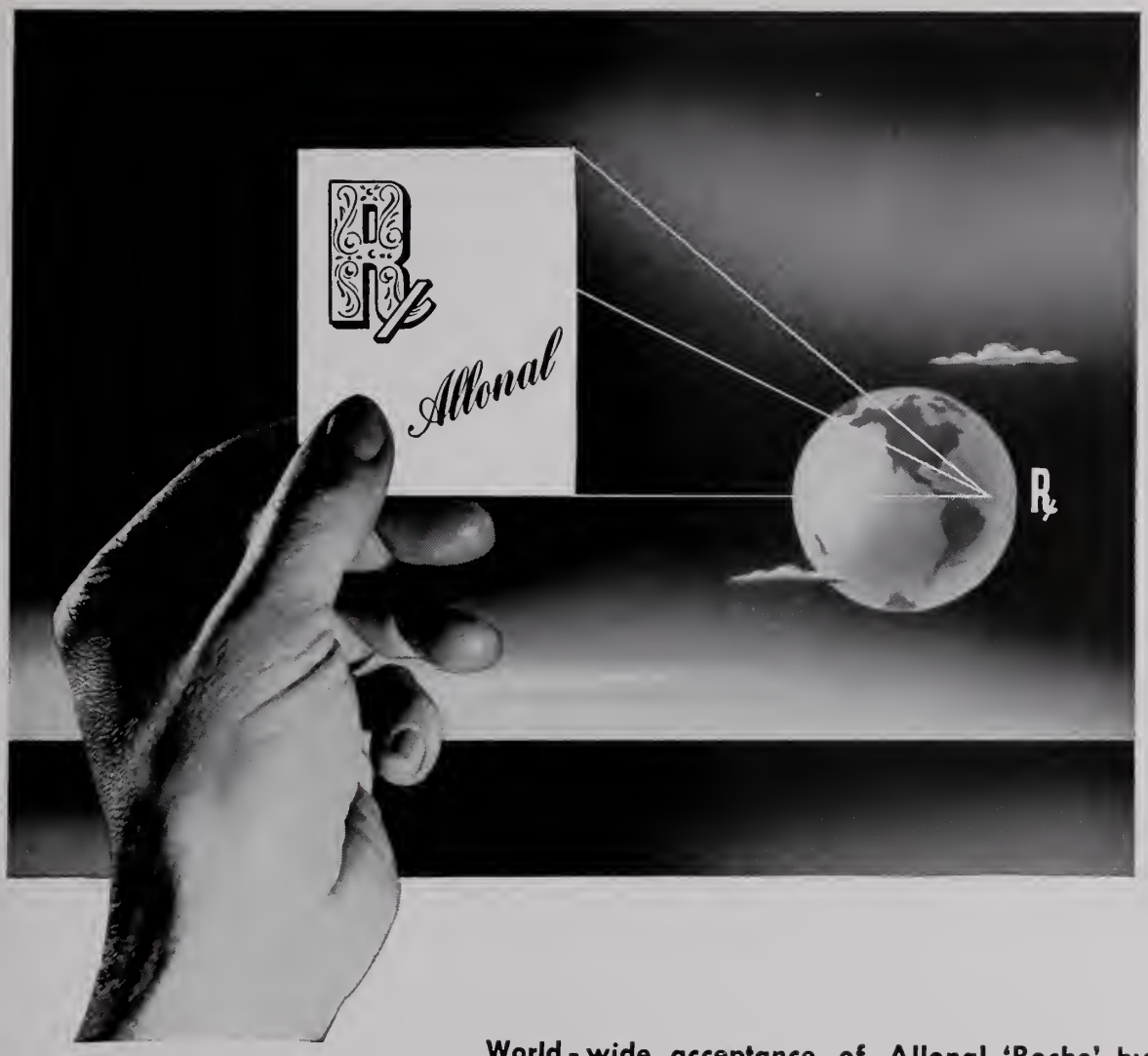
In applying these methods of administration to the various cases it was brought out that probably the best route would be by constant intravenous drip to a very sick patient, until he appeared out of danger, after which repeated intramuscular injections might be started.

Use of Drug in Local Infections

As for the proper method of dealing with meningitis or other local infections when one is dealing with penicillin it is still undecided. Each case must be decided on its own merits. Very few cases have been selected in which intraspinal injection has alone been tried and the majority of those that have been fortunate enough to receive the drug have usually had it both locally and parenterally, as well as in many cases receiving sulfonamide treatment at the same time. With such therapy it is obvious how difficult it might be to evaluate which of the drugs or methods of administration is the cause of the cure.

After this enlightening discussion, Dr. Anderson went on to discuss the bacteria affected and those not affected. In short, it might be said that the drug seems to be effective mainly against gram + bacteria, having known influence on only two gram — cocci, namely the meningococcus and gonococcus.

continued on page 239



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PROVIDENCE

AN INTERNE LEARNS OF PENICILLIN

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In fact in the list of organisms which he named as being affected by the drug these two were the most susceptible. Following in order of susceptibility were the hemolytic streptococcus, pneumococcus, staphylococcus, streptococcus, viridans and the large gram + bacteriae with the staphylococcus being about 1/10 as susceptible as the gram — organisms.

The reactions encountered with the drug may be dismissed with but a word and seem to consist of those minor ones attendant upon other drug toxicity.

Just how far this drug is going to go toward curing otherwise incurable diseases it is hard to say. However it seems fair to say that once the production of this drug has reached more than "pilot plant" production and when it is available for civilian use, many cases which do not respond to the usual sulfonamide treatment will be found to be cured or at least greatly helped by penicillin.

The remainder of the program was devoted to the presentation of cases by representatives of the various hospitals with comments by Dr. Anderson.

DOCTORS AT WAR

continued from page 235

WITH THE NAVAL FORCES

COMDR. EDWIN VIEIRA, MC, USMC, is one of five Rhode Island doctors holding that commission. Dr. Vieira was in the first class organized for Naval Reserve officers in aviation medicine at Pensacola, graduating from that group as a flight surgeon.... LT. COMDR. CHARLES HANSON, MC, USNR, for a long time stationed at Newport Naval hospital, is now reported as commanding officer of a mobile hospital in the South Pacific.... LT. COMDR. JARVIS D. CASE, MC, USNR, is now in charge of the epidemiological unit at the Naval Operating Base at Norfolk, and at not too distant Williamsburg, at the Naval Construction Training Center, LT. COMDR. BANICE FEINBERG, MC, USNR, is busy in the control of contagious diseases.... LIEUT. RAYMOND LUFT, MC, USNR, of Warwick, was assigned to ship service within a month following his enlistment, and he now has a Fleet P. O. number.... LIEUT. REGINALD ALLEN, MC, USNR, is located in Washington, D. C. on general duty.

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2—149-154.

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to be built up rather slowly in the majority of venereally acquired cases. In cases of accidental infection, because the infecting dose is probably massive in character, intradermal and complement fixation tests become rapidly positive.

Gutman[29] has reported that a moderate secondary anemia is common in the early stages of the disease. This observer has also noted the common occurrence of hyperproteinemia, due to large increase in serum globulin, in the various stages of lymphogranuloma but particularly in patients with chronic complications such as rectal stricture. This finding is of differential diagnostic aid before the skin test becomes positive. It is remarkable that this hyperprotenemia remains present for many years and may even be permanent.

Moderate leucocytosis and increased sedimentation rate occur. Frei[2] and Ravaut and Rabeau[30] have observed the occurrence of transitory, falsely positive Wassermann reactions in the early phases of lymphogranuloma.

The clinical picture of lymphogranuloma venereum may give evidence of either an acute or chronic febrile illness, the symptoms of which have been described as minimal in some cases while in others they have appeared marked and prolonged.

Symptoms may occur as follows: headaches, fever, rigors, sweats, chills, anorexia, nausea, vomiting, weakness, loss of weight, and prostration. Also common are muscular soreness and tenderness, joint symptoms, rheumatic pain, either passive or on movement, with or without heat or swelling, and sore throat. Conjunctivitis and rashes may occur.

It has been observed that constitutional manifestations rarely accompany the onset of the anorectal involvement, but as the disease progresses it produces chronic symptoms, including loss of weight, anorexia, insomnia and nervousness.

In the chronic forms of the disease, namely those that have persisted for several months, arthritis occurs in about 10 per cent of the patients.[15] The joints which show greatest predilection for infection have been classified in a descending order of frequency as follows: wrists, fingers, elbows, ankles and knees.[15] Hydrops may occur, with redness of the overlying skin, accompanied by great tenderness. Joint destruction does not occur, however, and full function is ultimately restored if the disease becomes completely quiescent or is cured. In untreated cases of lymphogranuloma venereum, arthritis may persist for years and in some instances become sufficiently severe to require bed rest.

In a brief discussion of differential diagnosis it is interesting to note that lymphogranuloma venereum, presenting various clinical manifestations, especially in the acute stages, has been confused with many acute febrile conditions because of the similarity in signs and symptoms. In fact, this disease has been confused frequently with other members of the venereal disease group and, in certain instances, with tuberculosis, malignant disease, acute rheumatic disease, acute respiratory diseases, and acute enteric disorders. Additional diseases which must be considered in a differential diagnosis of early-stage lymphogranuloma bubo in the inguinal area include Hodgkin's disease, lymphatic leukemia, bacterial infection and tularemia. The occurrence of elephantiasis, if not characteristic, may present difficulties in distinguishing it from granuloma inguinale, malignancy, tuberculosis, dysentery (bacillary or amoebic), filariasis, chancroid, actinomycosis and ulcerative colitis. Proctitis must be thought of where symptoms and lesions occur at the lower end of the intestinal canal. To further complicate the diagnosis, there is a very common occurrence of mixed infections.

Diagnostic Tests

Since 1940, which was the time that Rake, McKee and Shaffer introduced the yolk-sac antigen for use in the intradermal test for lymphogranuloma venereum, many reports have been made on the efficacy of this material over that of human pus and mouse brain.

The technique of testing patients for skin sensitivity to the agent of lymphogranuloma venereum is the same for both antigen and antigen control. This is true also for material prepared from other than the yolk sac.

Previous to injection, the skin of the flexor aspect of the forearm is prepared with alcohol. Following this procedure, specific antigen and antigen control are injected intradermally, and the skin reaction is read at 48 or 72 hours by measuring the diameters of the resulting papules. Any erythema, regardless of its extent, surrounding the point of injection is not considered significant.

With yolk-sac antigen, a papule of 6 x 6 mm., or greater, indicates a positive reaction if the papule produced by antigen control is 5 x 5 mm., or smaller. Standards of interpretation are different for mouse-brain antigen, but are the same for human-bubo-pus antigen.

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LYMPHOGRANULOMA VENEREUM

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A typical response of a lymphogranulomatous patient to yolk-sac antigen is easily distinguishable in that the resulting papule in positive reactions has a central induration. The control papule shows slight induration and is less than 5 mm. in diameter.

There is little question concerning the use of the complement fixation test as a valuable aid in the diagnosis of lymphogranuloma venereum, and on the basis of clinical results, this test appears to represent a lower threshold of immunity response than does the intradermal test. This is perhaps the reason that in the course of diminishing immunologic response the complement fixation test may be positive although the skin test is negative.

Reports[31, 32] of the value of the complement fixation test show that approximately 98 per cent of persons with clinical lymphogranuloma are positive when the test is properly performed, and that 95 per cent of normal persons clinically appraised do not give fixation. It has been observed further that 68 per cent of the sera of prostitutes or persons suffering from venereal diseases show positive complement fixation reactions for lymphogranuloma venereum although many of these persons will not exhibit clinical manifestations of this disease. This calls attention to the probable existence of large numbers of latent and potentially dangerous lymphogranuloma venereum infections in persons who are sexually promiscuous. It is important to remember, however, that there is a serologic relationship between the agent of lymphogranuloma venereum and that of psittacosis, atypical pneumonia, trachoma, inclusion conjunctivitis, mouse-pneumonitis, and acute meningo-pneumonitis.[33, 34, 35] Although the occurrence of cross reactions in complement fixation tests complicate the investigation of the extent of lymphogranuloma venereum in the general population, it is less serious than one would be led to suspect because of the relatively rare occurrence of the diseases mentioned and also because of greater variations in clinical manifestations of the different diseases.

Another problem of specificity which faces the clinician today in the accurate interpretation of the results of the complement fixation test for lymphogranuloma venereum is the occasional occurrence of patients with late primary and early secondary syphilis whose sera react with normal yolk-sac constituents and thus give apparent positive reactions. The non-specific nature of such reactions becomes apparent if normal antigen controls are included in the test.

The practical advantages of the complement fixation test include simplicity and rapidity of performance. A single test carried out with adequate controls and using a series of serum dilutions beginning with 1:2 requires no more than 1.6 cc. serum, and a sample submitted for Wassermann test can be employed equally well in the fixation test for lymphogranuloma venereum. There is no necessity for the patient to return a second time as is the case in the reading of the intradermal test. Extensive studies[36] made in a case of accidental laboratory infection indicate that complement-fixing properties may appear in the serum as early in the disease as within a week after the onset of symptoms.

All the indications that have been obtained so far are to the effect that this test is more delicate than the intradermal test.[36, 37] In view of the foregoing, it seems likely that the complement fixation test might prove very useful in comprehensive surveys of the incidence of lymphogranuloma venereum among the general population. In states where serologic tests for syphilis are legally required before marriage, for example, the samples of serum submitted could also be tested for lymphogranuloma venereum, and, where positive reactions are obtained, arrangements might be made for clinical examination and intradermal tests of the donors.

Following this procedure would aid immeasurably in bringing infectious cases of lymphogranuloma under control.

Epidemiology

The epidemiology of lymphogranuloma venereum presents some very interesting problems to both the physician and public health officer.

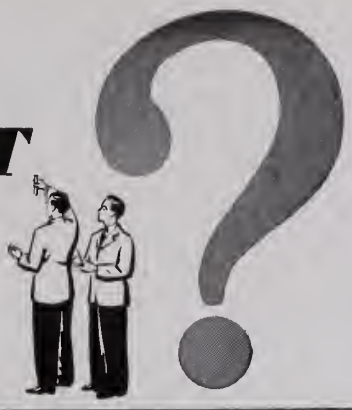
Exact data on the incidence and distribution of lymphogranuloma venereum are not obtainable because of the unsatisfactory means hitherto available for establishing correct diagnosis and also because of the fact that regulations for reporting this disease have not been provided in the majority of the countries.

In the United States a similar situation exists as seen by the omission of lymphogranuloma venereum in the list of communicable diseases for which notification is usually required by States.[38]

From 1920 to the present the greatest advances in diagnosing lymphogranuloma venereum accurately have been made. With the aid of the Frei test, clinicians in practically every country of the world have come to realize that this disease could be found among the peoples under their care.

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LYMPHOGRANULOMA VENEREUM

continued from page 244

During recent years the belief that the occurrence of lymphogranuloma venereum depended to some extent upon high temperature and humid climates has been disproved because of more definite knowledge concerning distribution and incidence of the disease. Although the majority of the reported cases have occurred in males, there seems to be no apparent reason that females should not suffer from lymphogranuloma venereum in about the same proportion. High incident rates are to be expected among prostitutes which influence the occurrence of more cases in the male population. The majority of the cases of the disease are found among those in the most active period of sex life, although cases have been noted in children.[15, 39] Lymphogranuloma is predominantly found among the colored race but such evidence does not justify the conclusion that they are more prone to the disease. The several factors of unhygienic environment usually encountered by this race probably influence the occurrence of a larger number of cases. The fact that there is high evidence of infectiousness of lymphogranuloma for humans makes it important to control the source of the disease as early as possible.

Because there is general susceptibility of persons to lymphogranuloma venereum, methods of control present problems which require the combined cooperation of the physician, patient and health officer. In this disease early diagnosis means that early treatment can be instituted. The early treatment of lymphogranuloma venereum means prevention of further spread of the disease. The infected individual must be controlled, and epidemiological studies should be carried out to discover the source of the infection. The use of general measures such as education in matters of social hygiene and adequate information concerning the aspects of the disease itself are more important.

Treatment

Many therapeutic measures have been employed in the treatment of various clinical manifestations of lymphogranuloma venereum, including the use of antimony, tartar emetic, salts of the heavy metals, arsenic preparations, iodine, topical application of Balsam of Peru to areas of ulceration on the external genitalia or anorectal region, roentgen rays on the groin or rectum, medicated enemas and supportive measures including iron and liver for secondary anemia, salicylates and heat for arthralgia, diet and rest. The use of surgery for aspiration, excision or incision, and drainage of buboes has been carried out extensively, notwithstanding the hazards associated therewith. Other surgical operations which have been performed with various degrees of success include iliostomy and colostomy with or without resection of rectum. Dilatation of rectal strictures has been practiced but for good results only experienced workers should perform such a procedure. Beginning in 1938 efforts were directed towards the evaluation of the sulfonamides in the various clinical manifestations of the disease. In addition to the use of these chemotherapeutic agents clinicians have investigated further the therapeutic results which could be obtained by the use of Frei antigen given parenterally.

Numerous reports have appeared on the use of the sulfonamides in the treatment of lymphogranuloma venereum. At present it appears that sulfathiazole and probably sulfadiazine contribute more effectively to the treatment of the disease than does sulfanilamide. Some of the best results have been obtained at the New York Hospital by Grace[15] who employs sulfathiazole in the early stages of lymphogranuloma venereum as follows:

> 1.5 Gm. administered orally three times daily for two weeks, then 1.0 Gm. three times daily for the next three weeks. A rest period was allowed during the succeeding three weeks after which treatment was resumed, beginning with 1.5 Gm. three times daily as above. In the inguinal cases of lymphogranuloma it was not deemed necessary to employ the drug in a second five-week course of therapy. Results obtained from this treatment of the disease showed a slightly more rapid response to sulfathiazole than was found with sulfanilamide. No toxic reaction was observed in the cases receiving sulfathiazole.

Several reports[15, 40, 41, 42, 43] have appeared in the literature attesting the value of the Frei antigen for the treatment of lymphogranuloma venereum in humans. Gray and Barnes[44] (University of Louisville Medical School) have experimented with both intradermal and subcutaneous methods and obtained good results. The intradermal route was considered the one of choice. Injections of the antigen were administered two or preferably three times a week, and improvement was usually observed within a two- to three-week period. Frei antigen has also been used intravenously by Grace who administered 0.3 cc. yolk-sac antigen every other day for twelve doses as a method of therapy

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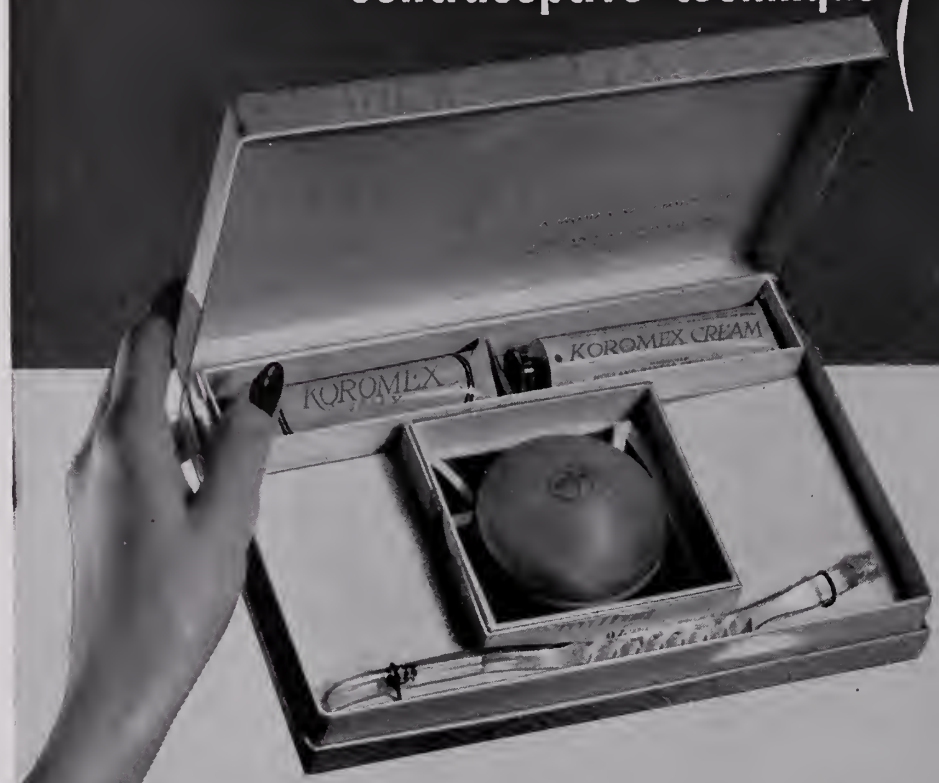
for lymph node involvement. The most recent report by Kornblith,[45] in which 3,500 injections were administered to 207 patients, shows striking results in the glandular (bubo) type of the disease, and symptomatic relief was brought about in cases with rectal lesions. Other investigators[46] have used sulfaguanidine for the treatment of the rectal type of the disease but results have not been particularly good. Because of the several different clinical manifestations of lymphogranuloma venereum, treatment must be adjusted to the stage and variety of the disease. At present there is considerable variance of opinion as to what the most desirable treatment methods should be. It should be remembered however, that the sulfonamides are comparatively new drugs, and this is true especially with respect to their use in patients with lymphogranuloma venereum. Nevertheless this group of compounds more closely approaches what at the present time may be judged the ideal therapy for this disease. Perhaps it might be necessary to supplement chemotherapy with specific therapy, i. e., the yolk-sac antigen in order to bring about the best results. As more therapeutic data becomes available it should be easier to determine which drug or drugs produce the most beneficial results.

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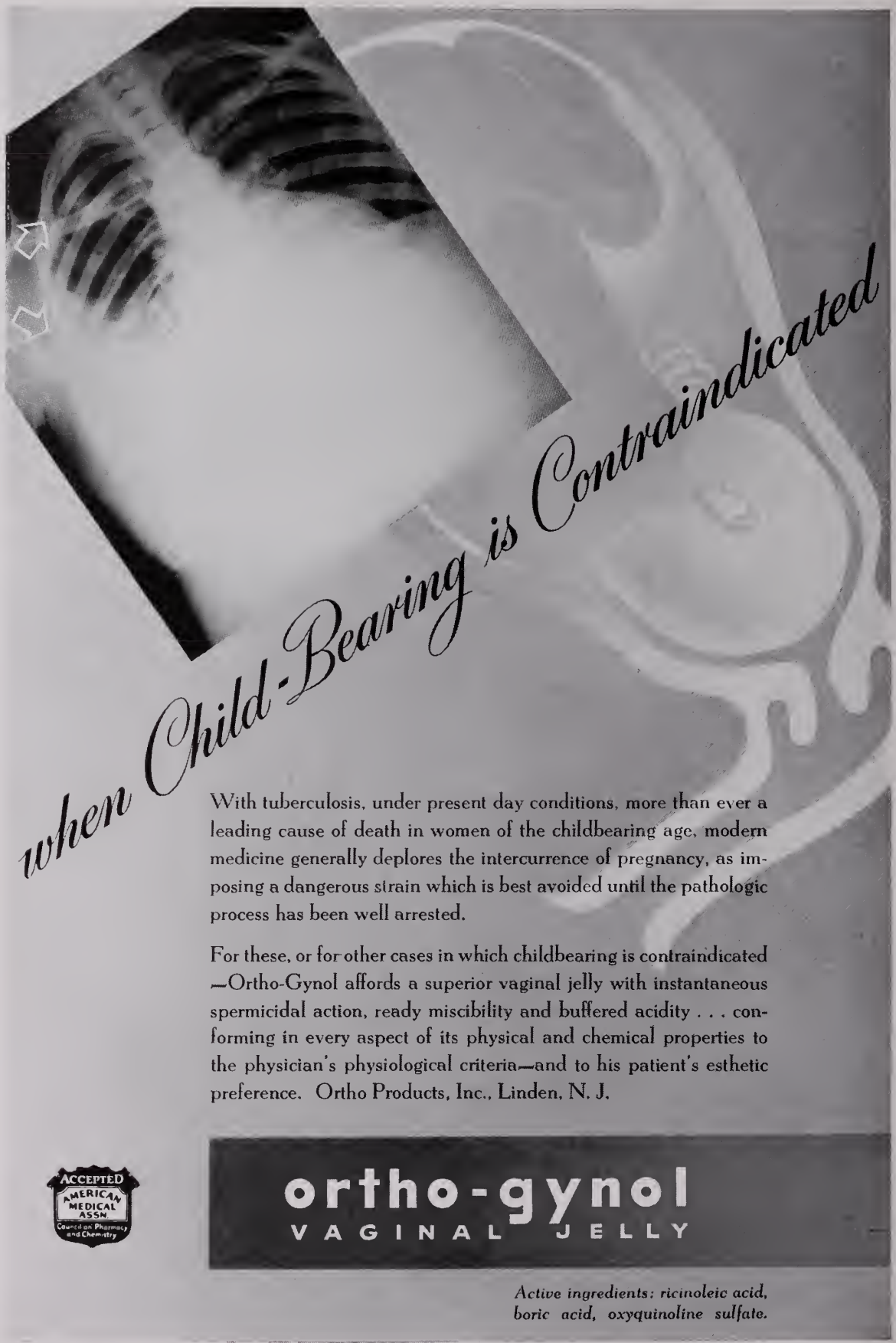
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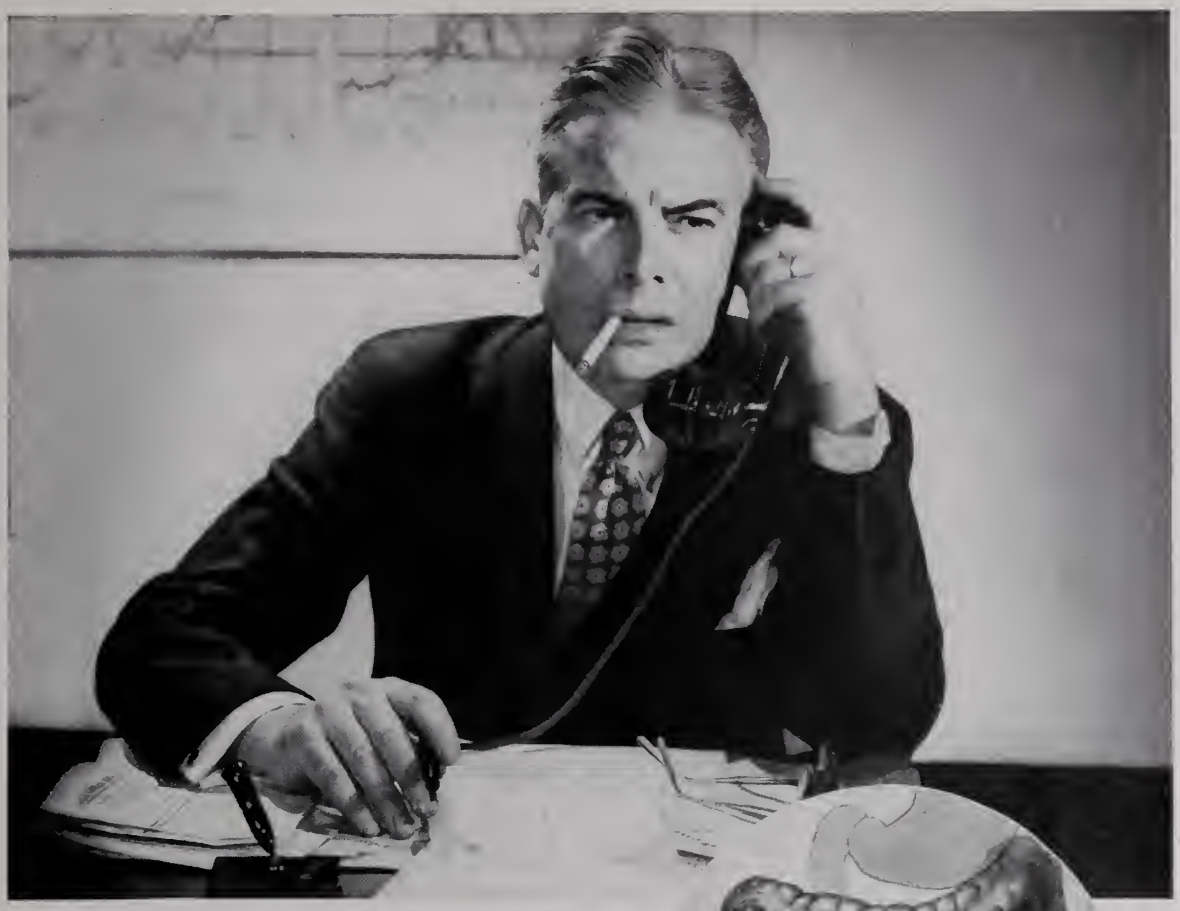
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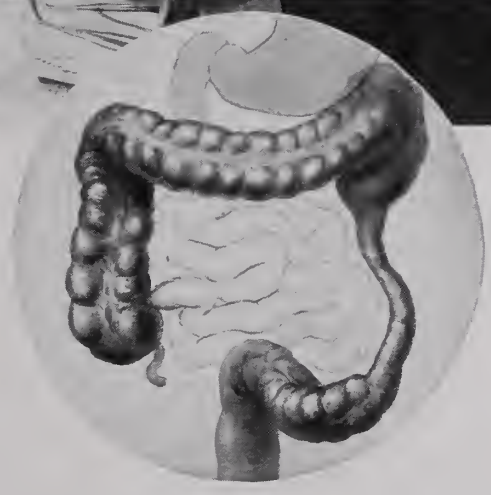
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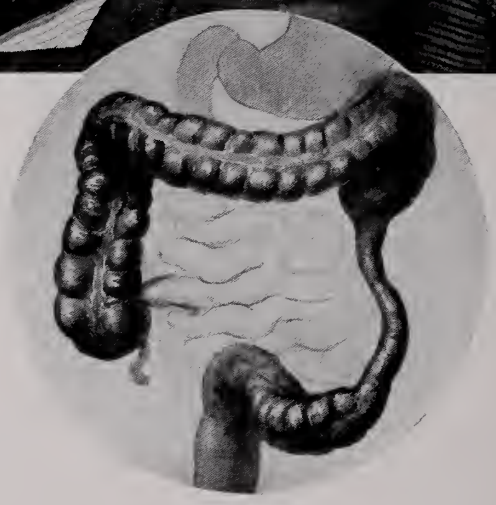
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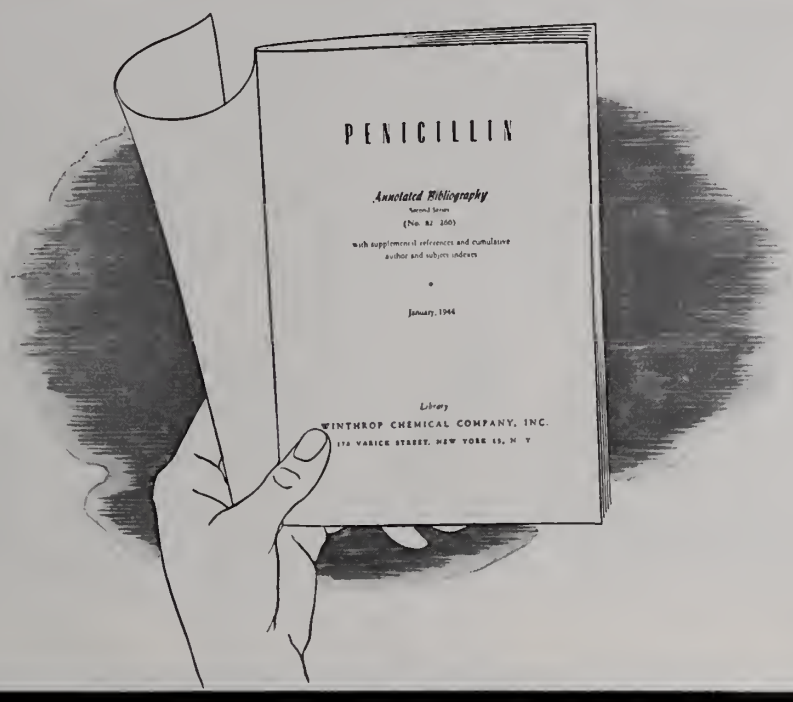
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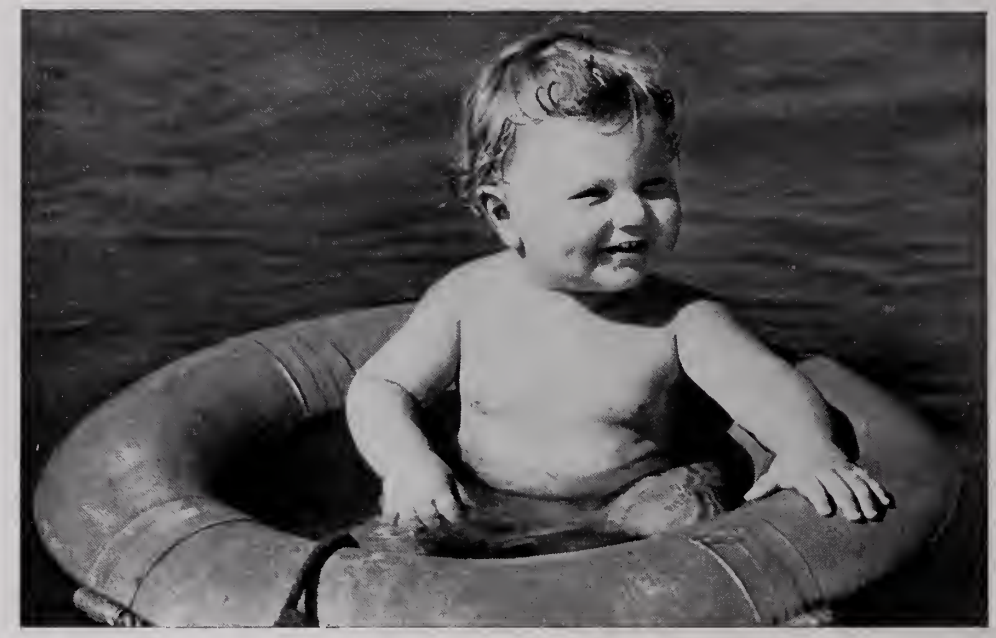
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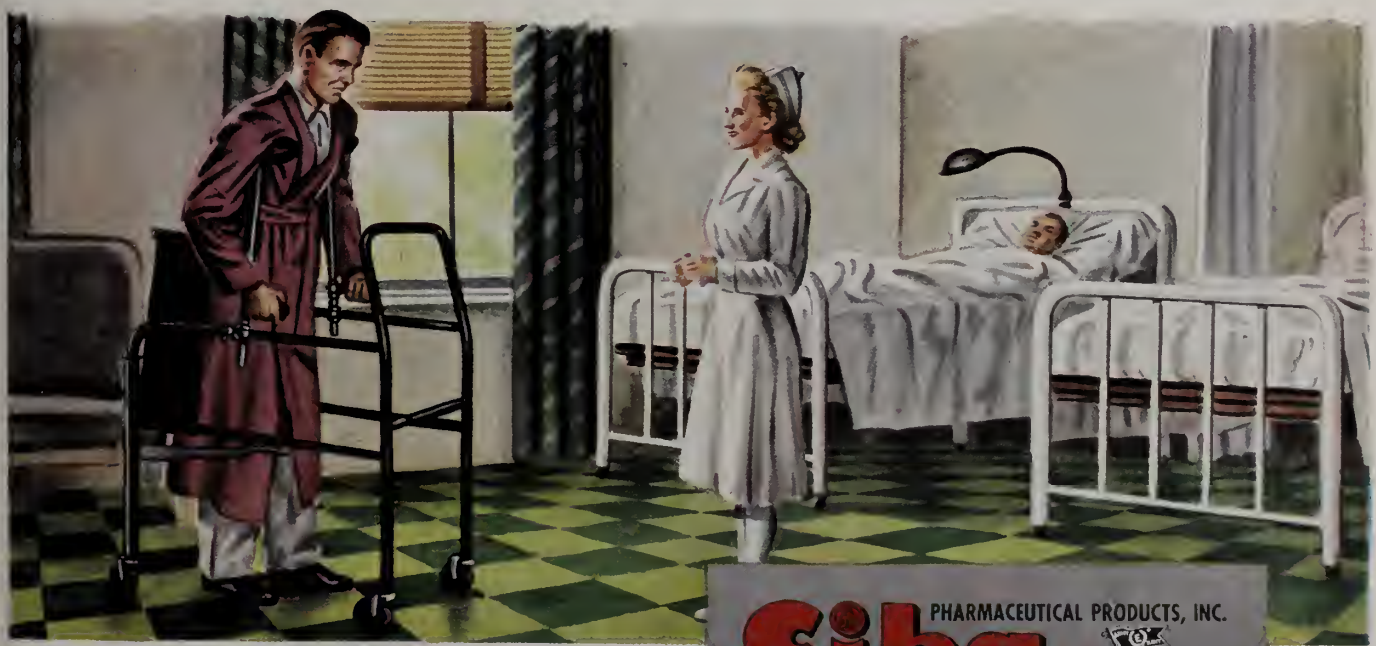


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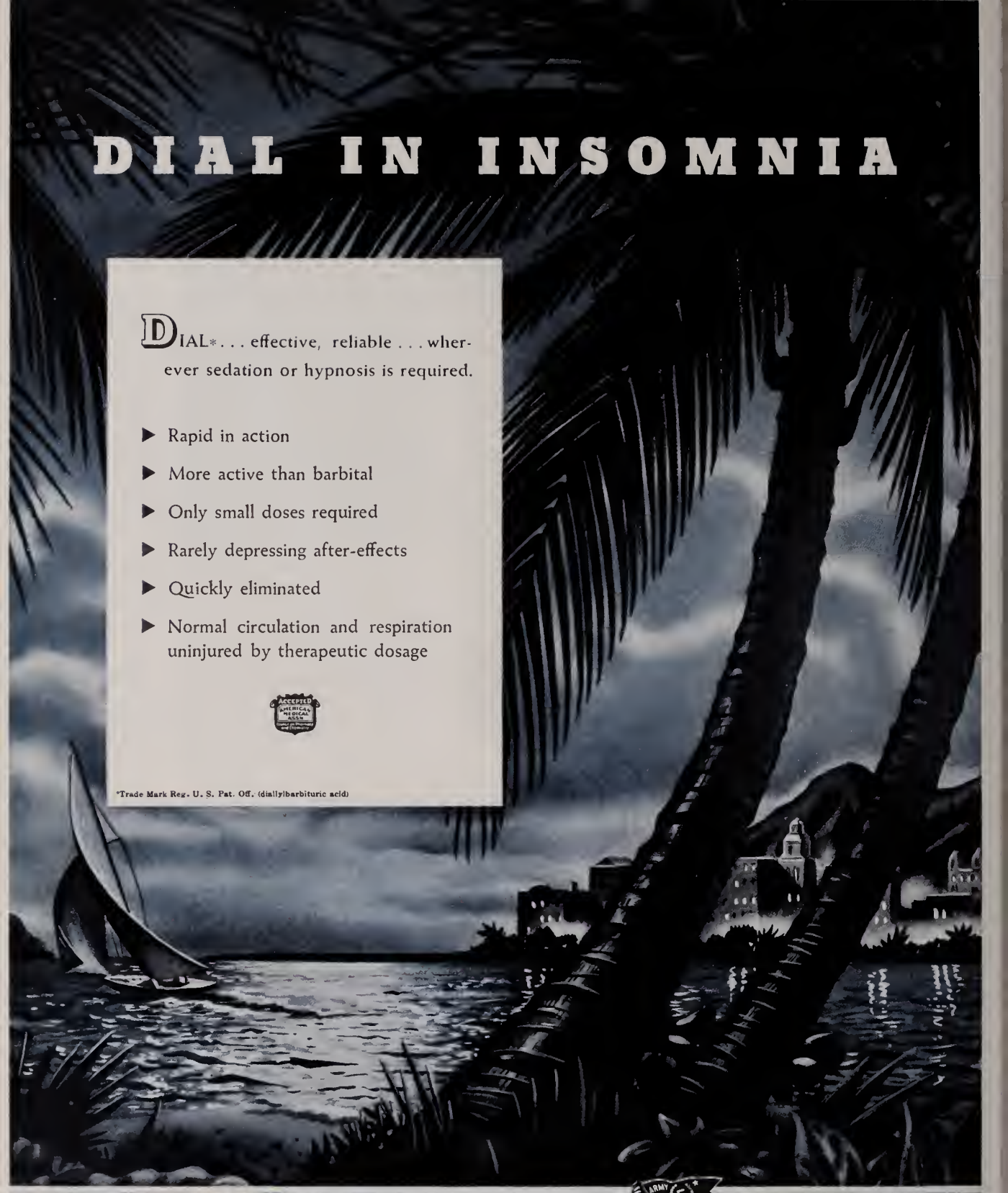
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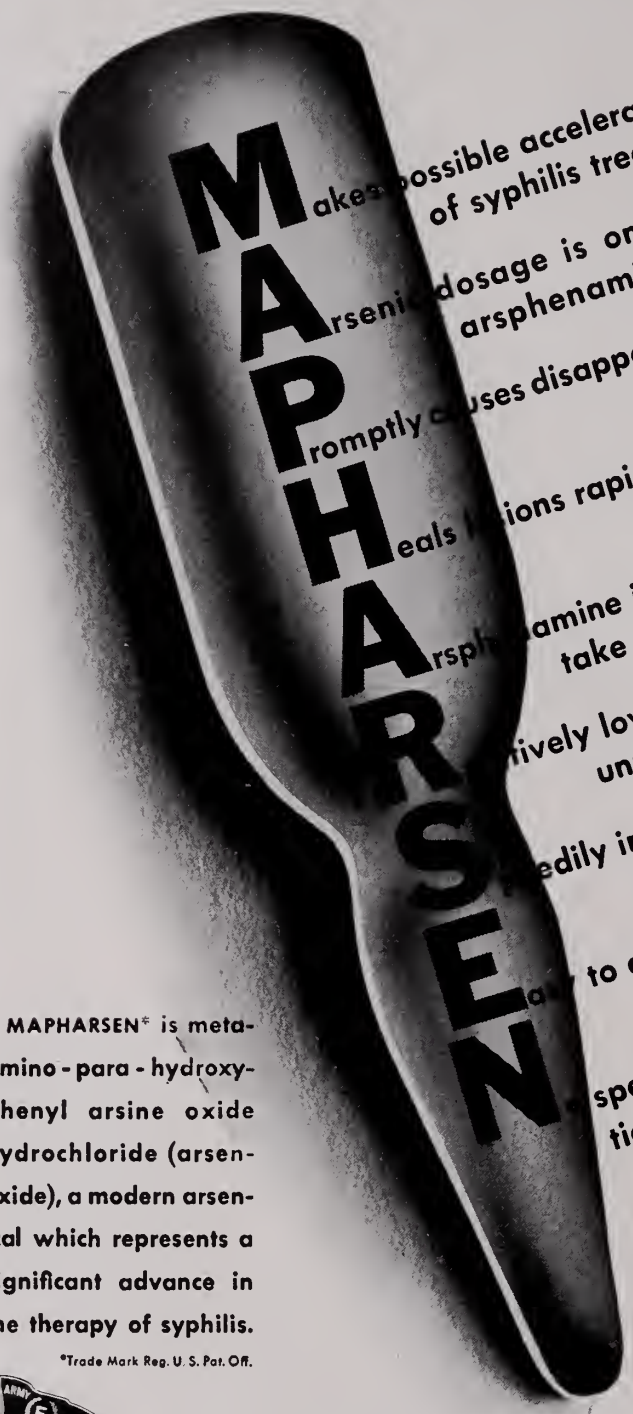
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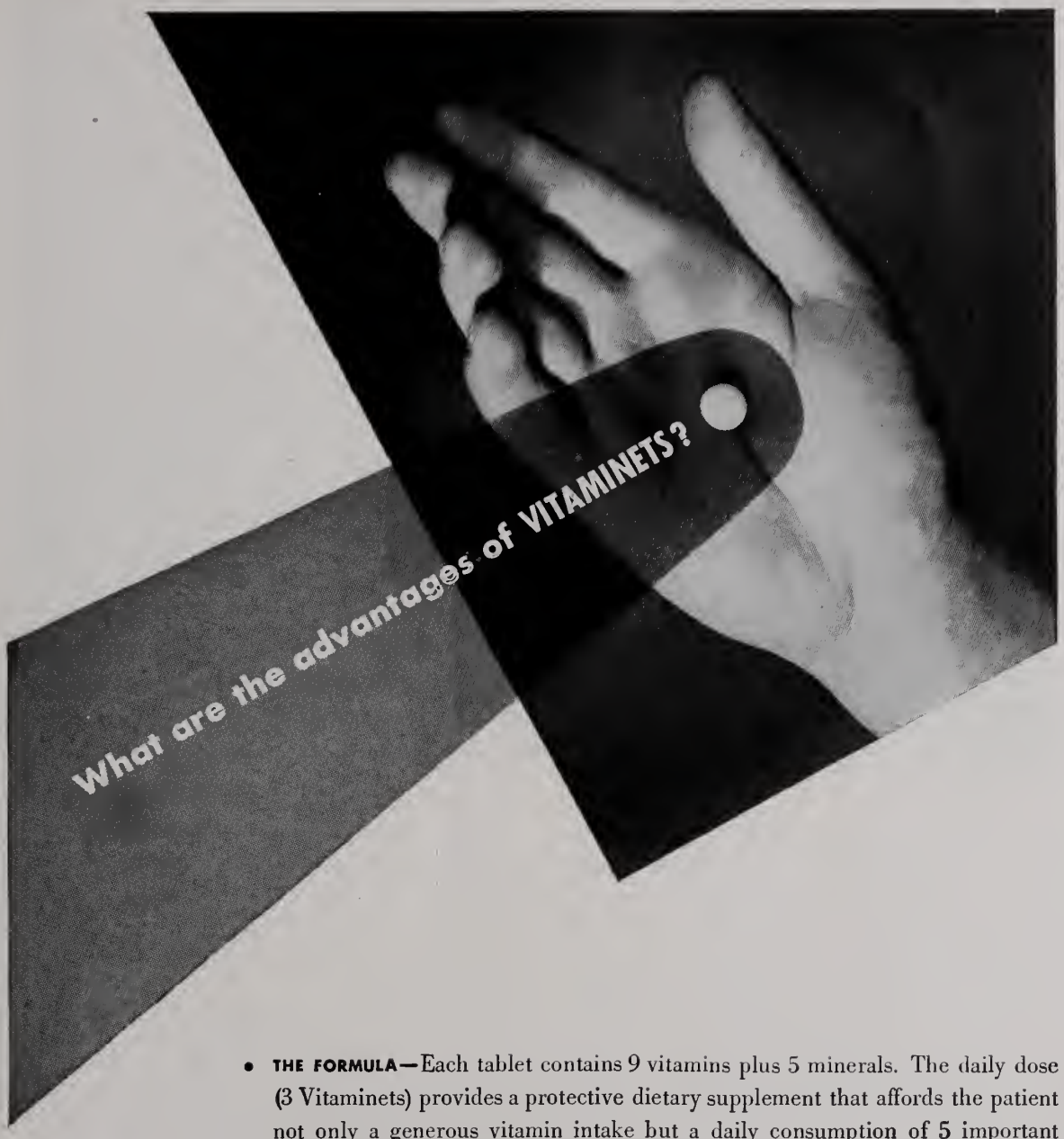
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The Author, *Reginald Fitz, M.D., F.A.C.P. (Bd. Regents); Consulting Physician, Peter Bent Brigham Hospital; Lecturer, History of Medicine, Harvard Medical School; Member, Council on Medical Education and Hospitals, American Medical Association.*

IT IS a great compliment to be privileged to deliver the Third Charles Value Chapin Memorial Lecture of the Rhode Island Medical Society. When Dr. Chapin received an Honorary Degree at Yale, Professor Phelps in presenting him to the University said that he was the leading figure in the development and standardization of public health practice in the United States, and President Angell added, "To have been instrumental in materially improving the health and happiness of untold millions is a noble achievement". Always each Chapin lecturer will wish to discuss some phase of public health out of respect for the memory of such a man. My predecessors, Dr. Leary and Dr. Place, were able to do this as experts, the one in the field of vascular disease and the other in that of contagion. In this lecture I shall speak on less restricted aspects of public health, not as an expert but as a clinician puzzling over some of the problems of American medicine which have become evident during the present emergency, and I shall hint at the part the Rhode Island Medical Society may play in helping to solve them.

The Distribution of Physicians

In each State the Procurement and Assignment Service for Physicians has largely completed its work of obtaining medical officers for our armed forces. In accomplishing this task all State Chairmen have accumulated masses of figures on cards which may assume unexpected shapes when they are shuffled, thrown in the air and allowed to drop on a sheet of paper in any way they choose. When my collection of cards is treated in this fashion they seem to me to fall in three fairly definite patterns.

About a third of the doctors normally employed in any community have been withdrawn for military service. In Massachusetts before the war, and I believe in Rhode Island too, there existed a striking relationship between the supply of physicians and the number of people engaged in gainful occupations. With us it proved far easier to persuade to volunteer for military service, doctors who were practising in areas where there was little industry and money circulated slowly than where the financial return from medical work was liberal. The fact that the majority of such men who were declared available did in fact enter miltary service brought to light a striking need for redistribution of medical manpower; for densely populated areas where business is brisk continue to have plenty of doctors whereas the thinly populated districts with less going on are depleted. How best to encourage returning doctors to enter practice in small towns where they are most needed is an important question which must be answered; something must be done to make rural or suburban practice attractive.

The Increasing Use of Hospitals

Another significant tendency is the increasing desire for the civilian population to utilize hospital facilites. This can be measured in a variety of ways. In 1915, in his President's Annual Address before this Society, Dr. Stephen A. Welch[1] spoke about some of the conditions affecting the practice of medicine in Providence. He exhibited certain charts which illustrated with what growing enthusiasm the hospital facilities here were being used. It is interesting to carry forward his data for another thirty-year period.

For seventy years the ratio between doctors and population in the city of Providence has been relatively constant, and since more than half the doctors of the state have been in the habit of living here and not more than one-third of the popula-

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*Presented at the Annual Meeting of the Rhode Island Medical Society on May 24, 1944 as the third Charles Value Chapin Memorial Lecture.

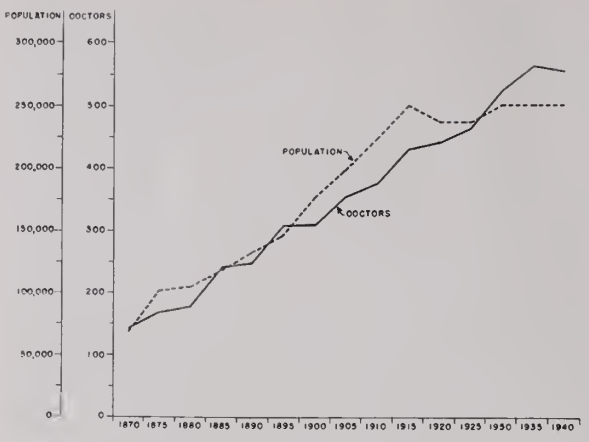


Chart 1. The growth of population and physicians in Providence from 1870-1942.

tion, it is clear that Providence has been Rhode Island's medical center for a long time. The increasing work year by year of three such representative institutions as the Rhode Island Hospital, the State Hospital, and the Providence Lying-In Hospital is also significant. This increase is far greater in proportion than has been the growth in population or physicians and it cannot be due entirely to the low cost of the professional care offered nor to the desire of persons insured by the Blue Cross or some other insurance plan to get something back for their investment. Much of it must be due to the inherited confidence that all Rhode Islanders have in these institutions and to their desire to benefit from the expert medical care which is supplied.

If one analyzes the career of any respectable hospital in any part of the country, the same growth in use is apparent. One may conclude, therefore, that the American people are now hospital-minded and will demand adequate hospital facilities in whatever community they live.

Medical Specialism

Dr. Welch mentioned that the tendency for doctors to specialize was an ever increasing one though I doubt whether he anticipated how far it would go. At a meeting of the House of Delegates of the American Medical Association in 1931, Dr. Carl T. Moll of Michigan introduced an unassuming resolution. Like Dr. Welch he was conscious of the growing desire for doctors to call themselves specialists and he considered this tendency unsound; therefore he asked the House to appoint a Commission on Qualifications for Specialists. From this beginning our present specialty boards were established and began to function. Each has its own peculiarities but with a common denominator; to become a qualified specialist in any field a doctor must have graduated from a recognized medical college, must have served an acceptable interneship, and must next have spent at least three years of intensive training in the specialty which he chooses to cultivate and two more in its practice. He may then be examined by his Board and if he passes the Board's examinations he is entitled to all the honors and privileges that go with responsible certified specialization.

Doctors who have been involved with any of the specialty boards have been impressed by their popularity. At each examination increasing numbers of young physicians appear and how to supply with proper opportunities for training all candidates who in future may desire to achieve the distinction of being registered as specialists is becoming increasingly difficult. This particular problem is a national one and is in reality a problem of postgraduate education. Opportunities for further training must be extended not only for the benefit of men who wish to become specialists but also for the benefit of medical officers who, on discharge from the Army or Navy, may wish further education before enterng practice.

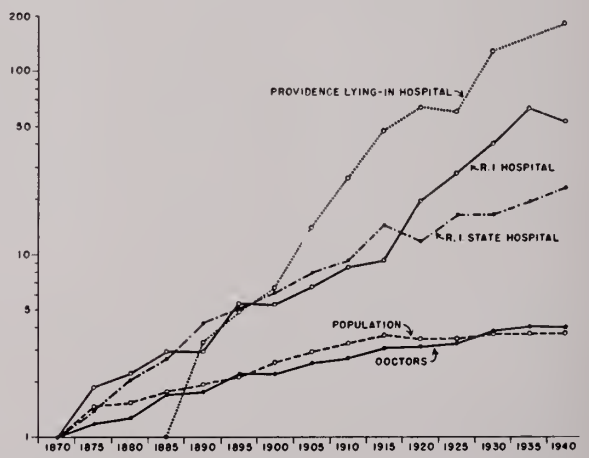


Chart 2. The relative growth in use of hospital facilities in Providence by patients contrasted with the growth of population and physicians. The data are plotted on logarithmic paper and carry forward those reported by Dr. Welch in 1915. The figures for numbers of patients treated were kindly supplied by the superintendents of the three hospitals considered.

For these reasons when my State Chairman's cards are shuffled, thrown in the air and allowed to drop on a sheet of paper, they now seem, to my mind, to settle always so as to form three distinct patterns: the pattern for the need of making rural or suburban practice attractive, the pattern for the need of planning on a future medical practice in which full use of hospitals and qualified specialists shall be made, and the pattern for the need of developing new and adequate opportunities for post-graduate medical education in regions outside of our present medical schools.

Post-War Planning

The hospital will always be the central point of post-war clinical instruction. For several years I have maintained a study of the New England hospitals approved for interne or resident training, puzzling over the perplexing problem of why some are so much better than others. It is a fairly simple matter to obtain data capable of tabulation from which comparisons may be drawn. A combination of information published in the Hospital Number of the Journal of the American Medical Association with statistics given in annual hospital reports, with the brief biographical notes of staff members reported in the American Medical Association Directory and with their bibliography compiled from the Quarterly Cumulative Index year by year, yields considerable information.

TABLE 1

Table 1. An analysis of three Massachusetts hospitals.

Situation	*Hospital "A" Boston*	*Hospital "B" City of 35,000 population*	*Hospital "C" City of 85,000 population*
Size	450 Beds	200 Beds	120 Beds
Internes	34	6	3
Beds per interne	13	33	40
Staff	Qualified specialists. Rare general practitioner.	General practitioners. Few qualified specialists.	General practitioners. Rare qualified specialist.
Necropsies per year	360	81	45
Publications by Staff Members during a year.	Many	Occasional	None

By way of illustration, a very simple analysis of three Massachusetts hospitals shows how marked are the differences that exist. Hospital "A" is a strong teaching hospital. Hospital "B" is less vigorous though functioning in a fairly satisfactory manner, and Hospital "C" is almost devoid of educational promise. If one happens to be acquainted with the hospitals one realizes where the differences lie. Hospital "A" has facilities with which to develop the best kind of clinical teaching and imagination with which to do so wisely, enough internes so that the work of each is performed handsomely, a staff mainly comprised of specialists many of whom are interested in research and teaching, a pathologist who appears to know his work and how to develop it. In brief, this hospital has a vigorous team of energetic people working together enthusiastically in an effort to make the record of their institution as perfect as possible. Hospital "C", in contrast, has too few internes to expect anything but superficial clinical work from them, a staff composed of physicians or surgeons who are not experts in any special subjects and may be indifferent or too busy to spend much time in teaching internes on ward rounds, and a department of pathology not well developed so that clinical correlation with necropsy findings—the most important educational experience in a clinician's life—is under-emphasized. Our modern young doctors flock to be trained in hospitals of the "A" type, and it is in the hospitals of the "C" type that the shortages of internes or residents are so acute. There are not enough "A" hospitals to meet the demand of those who wish to work in them and there is a plethora of the "C" class.

Every hospital which places itself on record as wishing to train internes or residents must recognize that in so doing it has assumed all the responsibilities of a teaching hospital. The staff, trustees, and superintendent must admit this fact and must cooperate to improve the opportunities for their pupils to receive adequate and proper instructional facilities.

No interne or resident should be appointed without a personal interview. His quarters should be attractive, his food good, and he should have adequate facilities for rest, privacy, study, and recreation. In Massachusetts about a third of the resident staff enter their institutions as patients at some time during their period of service. The amount of intramural illness should be kept as low as possible and this can only be acomplished by proper care of the personnel.

Staff, trustees, and superintendents must be prepared to work together purposefully so as to organize the best possible kind of teaching. A carefully

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considered and well-planned curriculum must be developed. Certain visiting staff members must be delegated to see to it that the work of the internes and residents is checked up; that the records are up to date and well and carefully written; that the laboratory and clinical work is properly done; that the physical examinations as recorded are acurate; that diagnoses are made correctly and that the technical aspects of treatment are carried out properly and systematically. A visit must be made each day to each of the patients under the direction of a member of the senior staff, unhurriedly and as a teacher, so that everything the internes or residents do can be scrutinized and criticized. In too many hospitals the work of the resident staff is haphazard and superficial. The self-taught young doctor acquires, besides bad habits, too much self-confidence and too little knowledge; he needs to be drilled in the art of practice, an art that can only be mastered by hard work intelligently controlled.

The interne or resident must be encouraged to grow and develop. He must be urged to take an active part in staff conferences and in other medical meetings held under the hospital's auspices. Hospital meetings must be conducted regularly and with a certain degree of formality. At such meetings an interne or resident should always present a case, learning to speak from his feet, without notes, and clearly and succinctly. He must be encouraged to write. Medical writing, if it does nothing else, stimulates a beginner to learn to use a library properly, teaches him to read, analyze, criticise and abstract literature, and also something of facility of expression and of the difficulties of composition —all good things for a young doctor's development.

Hospital trustees must be educated to realize that a teaching hospital requires certain equipment in addition to first-rate wards, laboratories, and operating rooms. There must be an enthusiastic, well-selected staff acting under good leadership. There must be enough resident personnel in proportion to the number of beds so that each of the resident staff may have a chance to think and work at something out of his routine. There must be a suitable place for medical meetings and this room should contain apparatus for demonstrating charts, X-Ray films, and pathological specimens. There must be a library in the hospital, readily accessible to the internes and staff, and it should receive sufficient endowment so that up-to-date textbooks and the more useful medical journals can be purchased.

The teaching hospital is always the one to visit; as Osler said, the work of an institution in which there is no teaching is rarely first class. The mere presence of internes and residents is inspiring but they can be attracted to hospitals only if for their efforts they obtain in return a broad, well supervised clinical experience. Thus an important step to make rural or suburban practice attractive lies in the encouragement of local hospitals to establish the type of interneships or residencies ordinarily obtainable in hospitals connected with medical schools; interneships where the work of each department is under the direction of qualified specialists, where the patients admitted are studied carefully and systematically, where staff conferences are active and interesting, and where the practice of progressive medicine goes forward vigorously.

I believe that the satisfaction and rewards of rural or suburban practice would be more apparent, better medical work would be done and greater use would be made of qualified specialism if more of the hospitals in our smaller cities determined to become "A" institutions. This already has been accomplished in certain instances with excellent effects.

Obviously, not all doctors who wish for postgraduate education can afford to spend time for a long period of hospital training. Methods for the growth of such men must be established as well as for the ones who hope to specialize. A Committee representing the American College of Physicians, the American College of Surgeons, and the American Medical Association has been at work perfecting a variety of short postgraduate courses which are proving remarkably popular. Oases for medical refreshment have been established all over the country and have sustained many travellers in regions which seemed barren. Such courses must be continued when the war ends and even improved. For fundamentally the vital subsidy by which doctors are rewarded for the better practice of medicine is not a financial one but is intellectual. Every doctor wherever he is, must be made to feel that he is an important part of the profession, he must be encouraged to improve the quality of his work, and he must be stimulated to broaden his education continuously. This is the goal which post-war planners should strive to attain.

The exact way by which this can be brought about in any universal fashion is still to be discovered. The chances are that no single method can be applicable everywhere. There is abundant room for experimentation.

The Medical Situation in Rhode Island

Rhode Island is one of the most promising states in the Union for the carrying forward of post-war planning along the patterns which I have suggested. It is a self-contained state with an area of about one thousand square miles, its population is about seven hundred thousand, and its present supply of active physicians is a little below six hundred. As has been mentioned, greater Providence (population 300,000) is the chief medical and civic center but also there are fairly large concentrations of population in Pawtucket and Central Falls (population 101,045), Woonsocket (population 49,300), Cranston (population 47,000), Newport (population 30,500), and Westerly (population 11,200). The distribution of phyiscians reveals the same war-effect as has been described for Massachusetts —a tendency towards concentration where industry is busy and for depletion in thinly populated areas. Thus more than 80% of the doctors are now found in these cities and the need for attracting physicians to return to smaller towns is as plain here as anywhere.

Rhode Island has four outstanding assets by which it might assume a position of significant prominence in medical post-war educational endeavors.

It is fortunate in having several large hospitals, excluding those for mental diseases and tuberculosis, placed geographically at strategic points: the Woonsocket Hospital in the north; the Memorial Hospital of Pawtucket, and the Chapin, Homeopathic, Lying-In, St. Joseph's and Rhode Island hospitals of Providence in the center; the Newport Hospital to the eastward; and the Westerly and South County hospitals to the south. All these hospitals except the two latter are large enough to offer attractive interneships or residencies if they wished to do so, and the Westerly and South County hospitals might be developed.

There is a wealth of clinical material in these hospitals. How diverse and varied this must be is illustrated from the following figures which are based on average performance for the five-year period. 1939-1943. (*See Table 2.*)

TABLE 2

Table 2. The clinical facilities of Rhode Island in general hospitals listed by the American Medical Association.

Hospital	*Census (Aver. per day)*	*Admissions (Aver. per year)*	*Births (Aver. per year)*
Woonsocket	86	3,332	729
Memorial (Pawtucket)	139	3,942	910
Chapin (Providence)	171	2,108	.
Homeopathic (Providence)	132	5,018	961
Lying-In (Providence)	125	4,319	3,928
Rhode Island (Providence)	367	9,273	. .
St. Joseph's (Providence)	228	6,692	1,227
Newport	110	3,203	637
Westerly	39	1,307	312
Total	1,397	39,194	8,704

Vast numbers of patients are being treated each year for these figures do not include out-patients. The quality of the work appears to be good. It is traditional for Rhode Island physicians to believe in careful clinical and pathological correlation and, as has been mentioned, this is always a reliable indication of professional zeal and interest. In these institutions an average of 600 necropsies were performed each year during the time in question and the average necropsy performance rate on fatal cases was 33%—a significantly good record.

I have amused myself by imagining all these hospitals linked together in some sort of a cooperative educational plan, a visionary thought, I agree, but entertaining to play with. It so happens that the Boston City Hospital is of about the size of the Rhode Island hospitals combined. Comparative figures are presented for what they are worth.

TABLE 3

Table 3. The normal number of interneships and residencies in the Boston City Hospital contrasted with the number customarily employed by the Rhode Island hospitals.

Hospital	*Census (Av. daily)*	*Admissions (Aver. per year)*	*Births*	*Internes Residents (Based on 1940 figures)*	
Rhode Island combined (1939-1943)	1,397	39,194	8,704	45	12
Boston City (1939-1943)	1,352	41,885	2,960	72	82

The Rhode Island hospitals and the Boston City Hospital appear to do about the same amount of general practice each year, the Rhode Island hospitals, however, having developed their work in

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obstetrics to a much larger extent. There is one striking difference which is worth stressing: the Boston City Hospital normally employed more internes and several times as many residents than did the Rhode Island hospitals. Surely, with the number of patients demanding hospital care each year, more young men in future might have the advantage of being trained in Rhode Island in special fields than heretofore. To have an interne or resident to every twenty beds was not excessive in teaching hospitals in the days of peace; on this rough estimate and if only proper arrangements could be made, Rhode Island might be able to afford valuable opportunities for clinical training to a large number of postgraduate students each year.

Admitting that the tendency to specialism is likely to continue, Rhode Island has for a second asset a number of qualified specialists who could be relied on to take the lead in guiding the establishment of appropriate residencies and short courses acceptable to their boards whereby a number of pupils might receive their basic clinical training in a satisfactory manner. How such residencies and courses might best be organized is, of course, a matter requiring most careful study but at least a nucleus of experts is at hand whose advice in such matters would be well grounded. The following table illustrates the wide diversity of qualified men to be drawn on, only those who are less than sixty-five years old being included. This arbitrary age limit was chosen in the belief that new developments require youth at the helm hence as much room as possible must be left for young men so that they will find space in which to grow.

TABLE 4

Table 4. Rhode Island Diplomates of Specialty Boards less than sixty-five years old, listed in 1942 Directory of Specialists.

Diplomates of Specialty Boards	
Anesthesiology	1
Dermatology and Syphilis	1
Internal Medicine	12
Neuro-Surgery	0
Obstetrics and Gynecology	10
Ophthalmology	6
Orthopedic Surgery	2
Otolaryngology	9
Pathology	2
Pediatrics	8
Plastic Surgery	0
Psycho-Neurology	9
Radiology	10
Surgery	6
Urology	0

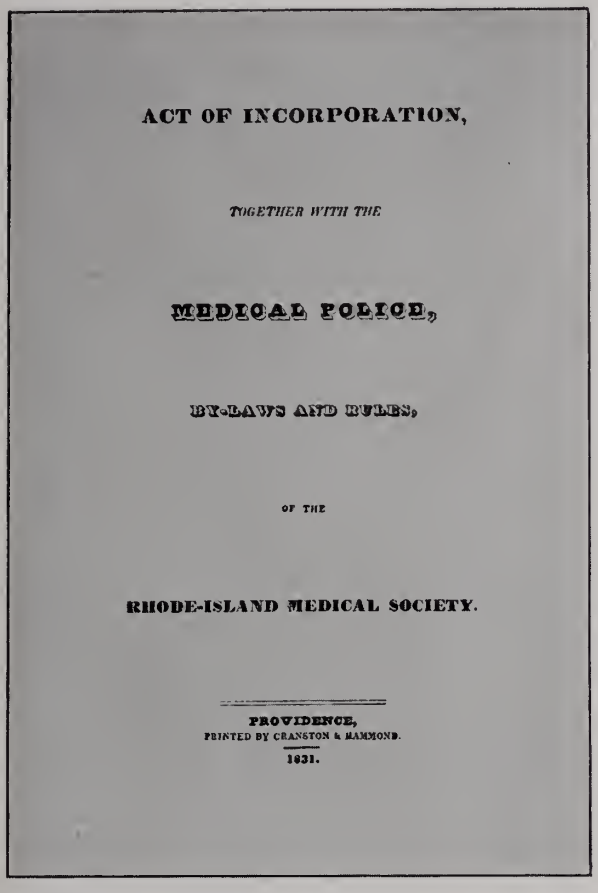
Each specialty board has one or more diplomates except neuro-surgery, plastic surgery, and urology, and no doubt these fields will soon be cultivated. It may be worth noting that these specialists are all located in Providence or Pawtucket — the two largest cities—suggesting that one of the driving forces behind the tendency towards specialism has been centripetal. It is important to establish a more even distribution of highly trained men outside of large cities and how to accomplish this is a baffling riddle.

Any effective attempt at postgraduate medical education, especially in so far as the training of specialists is concerned, can probably be best conducted on a strictly academic basis and therefore, if possible, under the sponsorship of a university. Rhode Island has for a third asset a potentially active medical school sired by one of New England's most revered universities.

In 1881, Dr. Charles W. Parsons[2] presented a most interesting paper before the Rhode Island Historical Society. He told how the charter of Brown University authorized its Fellows to confer any learned degrees which ought to be conferred in any of the colleges or universities in America; and how in 1811 three medical professors were appointed and a medical school was opened. The school did not prosper but fell into desuetude because, apparently, the matter of full-time teaching even in those early days raised its ugly head. In 1827 the Corporation deemed it essential to the administration of discipline and efficient teaching that all its officers be residents within the walls of the College and resolved that no salary or other compensation should be paid to any member of the teaching staff who lived outside and did not 'assidiously devote himself to the preservation of order and the instruction of the students'. This was too much for a part-time group of medical teachers to swallow and the result was that the Medical Department of the University faded away.

Dr. Parsons concluded his paper with a wise prognostication. Whether a medical school in Providence would ever be revived he did not know; a modern medical school, he said, to keep up with its rivals must have a vastly larger equipment of men and apparatus than was needed in 1811 and was hence a very expensive establishment: the decision as to whether or not a school would ever re-open in Rhode Island, he believed depended as much as anything on the enthusiasm, persistence and ability of its physicians.

Finally, for a fourth asset Rhode Island has a strong Medical Society. The State Society has kept alive for one hundred and thirty-two years the tradition of leadership in all matters pertaining to the improvement of medicine. The original act of incorporation and the first by-laws expressed this ideal with unique charm.



ACT OF INCORPORATION,

TOGETHER WITH THE

MEDICAL POLICE,

BY-LAWS AND RULES,

OF THE

RHODE-ISLAND MEDICAL SOCIETY.

PROVIDENCE,
PRINTED BY CRANSTON & MAMMOND.
1831.

Figure 1. Title page of Act of Incorporation of the Rhode Island Medical Society.

As is well known, in 1812 a group of fifty Rhode Island physicians founded the Society because they believed that the medical art was important to the health and happiness of their community. Their aim, they said, was to so organize the profession to prevent as far as possible unqualified persons from practising within the confines under their jurisdiction and their hope was to encourage greater skill by stimulating more enlarged views through education. The Society has lived up to this inheritance since its beginning and always has been recognized as being one of the strongest and most firmly knit medical societies in the country.

Four such assets as have been mentioned are in any state of incomparable value for the future of medicine whether they are applied to the training of young men who wish to qualify as specialists or to older men who need shorter and more intensive refresher courses. It would be gratuitous for an outsider to suggest means of procedure*. I can only express my belief that there is in Rhode Island an opportunity for developments in the field of medical education which I hope the Society will explore; perhaps through the establishment of an educational committee on which the hospitals might be represented and through which the latent promise of the state as an important focus of medical learning might be brought to maturity.

If there is anything to geomancy—that mystic art of divination from figures given by dots made at random—American medicine will be asked to make a second important contribution in the present emergency. Besides procuring sufficient medical officers for the needs of our armed forces, American medicine must reconstruct itself when the war ends, relocating physicians who wish to reenter practice, creating educational opportunities for those who wish to resume their training from where they left it off, and furthering a continuing education to all men in practice. The best way to accomplish this must be discovered. Every possible avenue must be inquired into with a view to its possible usefulness, new branches being transplanted on old ones wherever they promise to make healthy and enduring grafts. In this fashion, by adding to old ideas the new knowledge which medicine is acquiring through the sacrifices and hazards of war, when peace comes with it will come a new era of health.

* Nineteen years ago Dr. Halsey DeWolf[3], in his President's Address before the Rhode Island Medical Society, drew a comprehensive plan for the development of medical education in Rhode Island which is as modern and forward-looking now as it was then and which still deserves careful study.

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CHANGING ASPECT OF MEDICAL ORGANIZATION*

MICHAEL H. SULLIVAN, M.D.

The Author. *Michael H. Sullivan, M.D., of Newport, President, Rhode Island Medical Society, 1943-44.*

THE death of Dr. Murray S. Danforth within three days after he had been elevated by you to be the President of this Society automatically placed me in the office last June, the second member in the history of the Society to inherit this distinguished title. I must confess misgivings from the very start that I could contribute to the office and its many obligations and duties in any measure comparable to that which would have been possible under the leadership of that eminent and scholarly physician, Dr. Murray S. Danforth.

As presiding officer of the Rhode Island Medical Society I have had unusual opportunities to view the problems of present day medical organization. I hold forth no panacea for the problems of medicine, nor do I feel qualified to analyze in their complete perspective the trends of the day as they affect medicine. My efforts on this occasion will be merely to offer some observations after a year in your service as an officer of the Society.

From time immemorial medical men have gathered, just as we have here this week for the 133rd Annual Meeting of this Society, to learn whereby they may better serve their fellow men. Personal benefits as the result of such service are necessarily secondary. Upon such a basis has been the construction of medical organizations through the years, and upon that basis we shall meet in the years ahead to continue the progress of medical science and practice.

Social Side

Increasingly, however, are we becoming aware of the social side of medical progress. In the early days the physician confined his activities to the individual patient. As cities and towns developed there arose the additional need to supervise certain community matters which affected the health of the inhabitants, such as a pure water supply, the proper disposal of waste and sewage, the proper handling of food and food supplies and other measures to present the spread of communicable diseases. Pioneers such as our own Dr. Chapin, whose memory we honored last night, led the work in this field.

In addition, the care of the sick poor was necessary, and dispensaries were started for those who could go to them, while hospitals were established for those who needed bed-care. In more recent years we have witnessed the rapid trend toward preventive medicine, with emphasis on means to prevent diseases and thus to promote better health for the communities.

Thus over the past three decades, life expectancy in the United States has increased from 53 to 64 years. We may well look forward to the possibility that twenty years hence one-sixth of our population may live to sixty years of age or over. The saving of life, and the subsequent change in the age structure of the population, growing from medical advancement, necessarily created the need for social and economic readjustments. The magnitude of the problem is undoubtedly not fully appreciated as yet, and though programs of social security and old age pensions are efforts towards its solution, the results to the medical profession are yet to be felt in their full impact.

The diseases that now advance to the forefront as the result of the control of infectious diseases in the early years of life by reason of the brilliant discoveries of medical research, cannot be cured or prevented by science alone. They will be controlled only by the united cooperation of the individual members of the public with the physicians of this country, and the task of gaining that cooperation is one that will tax the ingenuity of every real physician.

Medicine has been faced with an increasing criticism in recent years of its failure to utilize the tremendous accumulated knowledge it possesses to control and prevent disease. We have been accused of failing to consider changing social conditions, of resenting the invasion of lay groups, whether political opportunists or sociological reformers, who

*Presidential Address to the Rhode Island Medical Society at Providence on May 25, 1944.

seek to remedy the faults of medicine. The criticisms will increase if propagandists continue to lull an uneducated public into the belief that health in the future will be assured merely by a meal of vitamin tablets, a spray of new insecticides to destroy germs, treatments with miracle drugs to conquer any malady, and social insurance plans to meet all costs.

Our answer to the problem is seemingly clear. We must re-examine and reconstruct our theories of public relations so that we may develop better cooperation between the patient and the physician, and a keener realization throughout the general public of the social application of medicine. We must lead or we will be led.

Review of the Work of the Society

Prefaced with these few observations a review of the work of our own Society as I have observed it for the past year takes on added significance and holds forth evidence of outstanding leadership toward social betterment and strong medical organization that we have within our ranks. The achievements of the year rightfully belong to the Society, and particularly to those unselfish members who have given unstintingly of their time and energy these busy days. Their work is monumental, and indeed a source of amazement to me when I realize the tremendous burden imposed on every physician during these troublous days.

The need for a central office for the Society with a full time administrative officer in charge has been increasingly noticeable within the past few years. Our largest district society, the Providence Medical Association, foresaw this need six years ago, and at that time created the first office of its kind in New England. Therefore, it was the good fortune of this Society, starting last July, to share with the Providence Medical Association its executive secretary whose scope of work had already absorbed many projects of state and nationwide import. The executive secretary, as you all know, is Mr. John E. Farrell, whose keen analytical mind and thorough knowledge of medical public relations has been of tremendous help to the Medical Society in these days when America's leadership in the medical world is being threatened by proposed legislation that would set up bureaucratic control of the medical profession.

Increase of Membership in the Society

Under the impetus of a re-organization program created and blue-printed by my predecessors, Dr. Murray Danforth and Dr. Charles Gormly, we have witnessed a remarkable growth of the Society. The membership has increased to the highest total in our history, with 702 fellows now registered on the rolls. The JOURNAL has expanded in content and in circulation until it now commands a place as one of the larger State medical publications of the country, and in addition it has become the first Journal to open its pages to the dental profession to serve as its official publication also. Committees have met regularly and the perusal of the reports of their Chairmen, which I commend to your reading, gives some inkling to the complexity and magnitude of their efforts in behalf of our communities as well as the profession.

The Rhode Island Society of Industrial Physicians and Surgeons

Taking the leadership which I have indicated as being so important to the success of our medical public relations, the Committee on Industrial Health has been the instrumentality which formed the Rhode Island Society of Industrial Physicians and Surgeons, and also the Industrial Nurses' Club of Rhode Island. Meeting regularly through the year these organizations now offer industry and labor in this most highly-industrialized area the assistance in medical and surgical problems that are certain to form a vital link in the whole scheme of better health for the future.

Education

Another committee of the Society that has been doing good work is the Committee on Education. Education is one of the duties of our Society. In our charter we are termed a Medical Society based on liberal principles. Therefore the Society should always be a leader in educating the public. About 16 years ago the custom of radio broadcasts was instituted as a way of bringing to the public the best in preventive and curative methods. In the past year these broadcasts have been greatly amplified. They are given every Saturday by members from different parts of the State, who recount to the public the most recent and remarkable achievements of modern medicine. They are given in a language not too technical, and easily understood by the people, and I am sure they are greatly appreciated.

Assistance to War Agencies

Through its executive office and its committees the Society has been of material assistance to every war agency that has sought its advice and aid. The Procurement and Assignment Agency, though not appointed by the Society, has been the vital service

continued on page 279



ELIHU S. WING, M.D.

of Providence, R. I.

President of the RHODE ISLAND MEDICAL SOCIETY

1944-45

PRESIDENT'S MESSAGE

DURING the past year the Rhode Island Medical Society has made much progress. In looking toward the future there are and will continue to be many problems facing us. We must not only keep up the high standards of our profession but also cooperate in extending our influence in all matters pertaining to the health of our citizens, particularly in the field of medical education and preventive medicine.

It is quite apparent that there are lessons for us physicians to be found in the recent remarks made at the Butler Hospital Centennial Exercises by Dr. Alan Gregg, director of the Division of Medical Sciences at the Rockefeller Foundation, when he urged in respect to institutions that they concentrate on research and teaching, and integrate their efforts with a regional health plan, rather than remain aloof—changing their form of organization and type of function so as to retain and acquire values and relationships not now possessed. He further urged for them organic relationships with medical schools and universities, not as a merger but as a partnership stressing the idea that medical care is changing in status, etc. We, as medical men, must tie into such a possible picture, if we are to retain our autonomy. The small State of Rhode Island by its traditional spirit of independence and initiative offers itself as good proving ground for such advice.

The future efforts of the Rhode Island Medical Society should include:

(1) Taking the lead in still greater cooperation among all agencies dealing with the health and medical care of our citizens; (2) Further general planning for various post war situations arising during readjustment days; (3) Immediate planning for increased cooperative medical educational facilities for ourselves and our citizens.

Many sign-posts point to the wisdom of such a course. Among them are:

The deductions to be made from the excellent and timely Charles V. Chapin Oration given at our recent annual meeting of the Rhode Island Medical Society by Dr. Reginald Fitz, a member of the American Medical Association's Council on Medical Education and Hospitals.

Implications applicable to us physicians in the remarks made by Dr. Alan Gregg, as previously mentioned.

The rapid advancement of the science of medicine in the past few years, especially when coupled with new post war releases based upon extensive war time medical research kept secret for military reasons.

Lessons brought home to us by our physicians and surgeons on various war fronts where they are dealing with a great variety of problems.

The need for a thorough working knowledge of diseases not heretofore familiar to most of us, due to the intermingling of our foreign service men with various tropical races and also by reason of contacts brought about through future extensive and rapid airplane transport service throughout the world.

The necessity for better acquaintance with nervous and psychiatric problems arising out of war strain and tragedy.

More knowledge pertaining to rehabilitation of our physically, nervously or mentally impaired war veterans.

With the above thoughts in mind, immediate planning would seem necessary, and therefore I propose that the Rhode Island Medical Society establish, in cooperation with district societies and various hospitals in our state through the hospital association, educational clinics and other cooperative aids for the benefit of all the members of our profession and the betterment of our hospital services.

To avoid delay, I wish to make it my first official act to appoint a committee to study this proposal and possible ways and means of formulating a cooperative educational plan to be presented to the House of Delegates of the Rhode Island Medical Society at its next meeting for its action.

With power to enlarge its membership as it may deem wise, this Committee is appointed to consist of Dr. Alex M. Burgess, Dr. Charles A. McDonald, and Dr. B. Earl Clarke.

ELIHU S. WING, M.D., *President*

The RHODE ISLAND MEDICAL JOURNAL

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106 Francis Street, Providence, Rhode Island

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1944 ANNUAL MEETING

The one hundred and thirty-third annual meeting of the Rhode Island Medical Society was held in Providence May 24th and 25th with headquarters at the Medical Library. This was certainly the most outstanding meeting in recent years and possibly in the long history of our State Society, particularly in terms of attendance and quality of the programs.

Although one hundred and seventy-seven Fellows of the Rhode Island Medical Society are absent in the armed forces, most of them at points too distant to permit attendance at the annual meeting, the registration was the largest since accurate figures have been kept, with four hundred and five physicians and two hundred and six lay guests having registered.

New and stimulating feature of the meeting this year was the fact that it extended over three days with the Rhode Island Society of Industrial Physicians and Rhode Island Industrial Nurses' Club meeting at the Medical Library on May 23rd and the Rhode Island Association of Medical Record Librarians meeting at the Library the morning of May 24th. Through the enthusiasm and organizing ability of our Executive Secretary, Mr. Farrell, the commercial exhibitors, whose presence and displays have been an important feature of our meetings for most of the past decade, were present in nearly twice the number of any previous meeting.

The Program Committee is to be particularly congratulated on arranging for fewer papers than in the past and these all of the highest quality. The result was that under the presiding genius of our President, Dr. Michael Sullivan of Newport, the schedule did not lag, there was no pressure of hurry, and those in attendance had ample time to both enjoy the scientific presentations and visit in comparative leisure the many exhibits on all three floors of the Library. The exhibitors themselves were much gratified at the fact that the doctors in attendance not only showed interest in the various displays but took the trouble to register and thus give tangible evidence of their attendance and interest, which is always essential to the home offices of firms which contribute so materially to the success of our meetings. The innovation of having a Snack Bar close to the exhibits on the basement floor, which was able to rapidly furnish a light lunch to physicians who might otherwise have sacrificed a noon hour, was a further added attraction. A well-attended cocktail hour at the Biltmore Hotel after the Wednesday afternoon session, sponsored by the Officers of the Society, was much

appreciated by members and guests, as was luncheon at the Rhode Island Hospital on Thursday following the morning clinics.

The scientific program itself consisted of original presentations on the afternoons of both days at the Medical Library, a clinic at the Peters House, Rhode Island Hospital, the morning of May 25th in which representatives of a dozen or more of the hospitals throughout the State each presented ten-minute discussions based on experiences in their own hospitals, and the Charles V. Chapin Oration at the Medical Library on the evening of May 24th. This annual oration has been officially sponsored by the Providence City Council, and the Society was honored by preliminary remarks and attendance at this oration by His Excellency, Governor J. Howard McGrath and the Acting Mayor of Providence, William A. Cahir. Dr. Fitz's analysis of the ages and interests of physicians now serving in the armed forces and in communities of various sizes and types on the home front was both timely and interesting. He pointed out the desirability and practicality of improving the standards of medical work in all our communities by making each hospital in the State a center of medical education, particularly in the postwar period.

The meeting was brought to a conclusion the afternoon of May 25th by the Presidential Address of Dr. Sullivan, who in the spirit of personal humility and modesty gave a masterly review of the activities of the State Society under his leadership during the past year, a record of which we all may be proud. The new President, Dr. Elihu S. Wing of Providence, was then escorted to the platform, and the new Vice President, Dr. F. G. Taggart of East Greenwich, and the President-Elect, John F. Kenney of Pawtucket, were likewise presented and enthusiastically received as the one hundred and thirty-third meeting was adjourned.

SAVING THE WOUNDED

Among the most dismal statistics of war—until this one—have been the figures of losses from wounds and disease. Between them these staggering losses have decided far more campaigns than actual fighting has.

It is not so this time. The medical and flying forces have co-operated to achieve a victory almost incredible. Scientific precaution has banished serious epidemics from even the most plague-ridden spots of the earth.

In our American forces the doctor, advancing abreast of the fighting man, has saved 97 out of every 100 wounded soldiers. He has saved from seven to eight of every ten soldiers who have suffered abdominal wounds, a complete reversal of the figures of our Civil War.

In less than two years our military planes have removed more than 173,000 sick and wounded soldiers from battle areas to places where they could receive more thorough treatment. In the millions of miles which these planes have flown with men desperately ill only eleven deaths have occurred in flight.

Never in the long history of war have there been such impressive achievements along any line.

Editorial—*Providence-Journal Bulletin*, April 4, 1944.

The City of Providence

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

CHAPTER 1254

No. 162. An Ordinance creating a standing committee of the City Council to be known as the "Dr. Charles V. Chapin Memorial Award Committee", and appropriating the sum of three hundred fifty ($350) dollars for the expenses of said Committee.

Approved April 21, 1944

Be it ordained by the City of Providence:

SECTION 1. A Standing Committee of the City Council is hereby created, consisting of five members of the City Council to be appointed by the President of the City Council, and to be known as the "Dr. Charles V. Chapin Memorial Award Committee." The members of said Committee shall be appointed as soon as may be after the passage of this ordinance and in the year 1945, and bi-ennially thereafter shall be appointed as soon as may be after the organization of the City Council. The said Committee shall cooperate with the Rhode Island Medical Society in arranging for the presentation of the annual meeting of the said Society of an oration to be known as the "Dr. Charles V. Chapin Oration."

SEC. 2. The sum of three hundred fifty ($350) dollars is hereby appropriated for the purpose of defraying the expenses of said Committee. Said sum or so much thereof as may be necessary shall, in addition to the necessary expenses of said Committee, be used in helping to defray the expense of procuring the speaker selected to deliver the oration, and in providing for a suitable medal to be presented to the speaker at the time of the annual address, by the Mayor of the City of Providence. Payments against said appropriation shall be made by the City Auditor upon voucher duly approved by the Chairman of the Committee.

SEC. 3. This ordinance shall take effect upon its passage.

A true copy,
Attest:

W. Earl Dodd, *City Clerk*

Learn something about your War Bonds from this fellow!



THE BEST THING a bulldog does is HANG ON! Once he gets hold of something, it's mighty hard to make him let go!

And that's the lesson about War Bonds you can learn from him. Once you get hold of a War Bond, HANG ON TO IT for the full ten years of its life.

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Another reason you buy War Bonds is because you want to set aside some money for your family's future and yours. No one knows just what's going to happen after the war. But the man with a fistful of War Bonds *knows* he'll have a roof over his head and 3 squares a day no matter *what* happens!

War Bonds pay you back $4 for every $3 in 10 years. But, if you don't hang on to your Bonds for the full ten years, you don't get the full face value, and . . . you won't have that money coming in later on.

So buy War Bonds . . . then *keep* them. You will find that War Bonds are very good things to have . . . and to hold!

WAR BONDS to Have and to Hold

The Treasury Department acknowledges with appreciation the publication of this message by

THE RHODE ISLAND MEDICAL SOCIETY

CHANGING ASPECT OF MEDICAL ORGANIZATION

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to supply the demand for physicians for the armed forces and at the same time guarantee care for the civilian population. The Office of Price Administration has the services of an Advisory Committee which serves as a clearing bureau for all contested requests for supplemental rations predicated on health needs. The State War-Manpower Commission's request for help in solving its medical problem resulted in the drafting of regulations and a record form which has become the pattern for the country. The Office of Civilian Defense and its Civilian War Services Branch have had complete cooperation from our membership.

Medical Legislation

The outstanding proposal of Dr. Emery M. Porter in his presidential address before the Providence Medical Association for a statewide council on health to embrace membership in lay as well as professional groups, the first definite proposal for such an agency in the country, won immediate approval. Subsequently, the House of Delegates acquiesced to the request of Governor J. Howard McGrath that he be allowed to appoint this health council. The work of that group, which included eleven doctors of medicine, has been reported to you through the daily press and needs no further amplification here. Recently the Council of the Rhode Island Medical Society instructed its Committee on Medical Economics to undertake a study of medical and surgical insurance plans under medical society sponsorship, and to report its findings to the House of Delegates as soon as possible.

Cash Sickness Act

The year has witnessed the completion of the first twelve months of active operation of the State Cash Sickness Compensation Act, the first plan of its type in operation in the country. We have objected when it was apparent that the interests of the public were not being served satisfactorily as regards the medical certification under the program, and we have seen our position vindicated. I have appointed a representative committee of the Society which now meets regularly with the Unemployment Compensation Board and which will endeavor to clarify the health phases of the cash sickness act program.

These, then, are achievements of which we may well be proud. They offer proof anew that the physician, no matter how busy he may be, is never too busy to concern himself not only with the ailments of his patient, but also with the general health needs of the community. What we have done here in Rhode Island is certainly comparable to the best in other areas. It was my hope during the year that a council of the medical societies of New England might be established for the exchange of ideas and for the planning of community interests. That plan has not materialized yet, but I trust that my successors will see fit to give it further study and consideration.

I would be remiss in my duties as I complete my term as acting head of the medical profession of this State if I did not pay tribute to those of our colleagues who have answered the call to serve with the armed forces in the defense of the country. At the present time there are 175 of our members serving on the many worldwide fronts, carrying forward to new glories the traditions of American Medicine. We are proud of their work, and we pledge them our support in every way when they return and again resume their places in civilian practice in our communities. In their absence they should be shown every protection against the inroads of foreign refugee physicians.

SCOUT CAMP SEEKS DOCTOR

Narragansett Council, Boy Scouts of America, operating the largest boy scout camp in New England, is seeking a doctor—or doctors—to serve part or full time at Camp Yawgoog in Rockville during the months of July and August.

Facilities at the camp are available for the doctor's family with complete living quarters. The camp has a fine Health Lodge with treatment room, waiting room, a ward with eight beds, a laboratory, two isolation wards and all modern facilities. The work is not tiring as the boys are a healthy group but occasionally one of them has an accident or is "upset" in some way or other.

If any doctor is interested in spending a week or longer at the Camp, thereby enjoying a vacation away from the city with his family, and at the same time contributing immeasurably to the protection of the health of these "men of tomorrow", he is urged to communicate immediately with Boy Scout headquarters at 26 Custom House street in Providence, or with the executive office of the State Medical Society.



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DOCTOR, has this ever happened to you?

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RHODE ISLAND STATE DENTAL SOCIETY

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BLUE CROSS MEMBERSHIP

The Hospital Service Corporation of Rhode Island (BLUE CROSS) again offers membership to dentists who are members of the Rhode Island State Dental Society. Application blanks may be secured by writing to the Secretary, Dr. Charles McKivergan, 102 Waterman Street, Providence. The membership list for Blue Cross will be made available only until JULY 1. Applicants accepted will be eligible for benefits starting August 1.

DR. GRUEBBEL VISITS US

Guest at the May meeting of the Board of Trustees of the Society was Dr. Allen O. Gruebbel, executive secretary of the Council on Public Health of the American Dental Association. Dr. Gruebbel gave a half hour talk on dental problems and their solutions in other States, and he accepted a report of dental problems local to Rhode Island for a national report to the central office.

DENTAL CORPS IN NAVY

At this writing H. R. 4216, a bill which would create a separate department for the Dental Corps in the U. S. Navy, is much in the limelight and deserves the support of every dentist. Honorable John E. Fogarty, member of Congress from the 2nd Rhode Island district, has gone on record as working actively for the passage of the bill in reply to the urgings of the officers of this Society.

DELEGATES TO A D A MEETING

Dr. Dring has announced the appointment as delegates to the American Dental Association meeting at Omaha, Nebraska, October 9-11, of Dr. Thomas W. Clune and Dr. Archie Albert. Alternates named by President Dring are Dr. Albert L. Midgley and Dr. Norman H. Fortier.

NEW MEMBER

The Secretary reports the election to membership of Dr. Bernard H. Meshnik of 40 Portland street, Providence.

REPORT OF SPRING MEETING

The Spring Meeting of the Society was held at the Narragansett Hotel on April 26. At the business session reports were given by the following chairmen: Dr. Frank Ackrill, Ethics Committee; Dr. Archie Albert, Legislative Committee; Dr. Harry McKanna, Oral Hygiene and Public Health Committee; Dr. Norman Fortier, Publications Committee; Dr. Edward Morin, Horace Wells Centenary Committee.

Guest speaker at the meeting was Dr. Powell C. Carrell, M.P.H. who is in charge of the dental program of the Pratt & Whitney Aircraft Corporation at Hartford. Speaking on "Industrial Dentistry and the Industry of Dentistry", Dr. Carrell explained the survey which he is making to determine facts in a constructive dental program which will be of value to management, labor and dentistry by reducing absenteeism, by providing better health for workers, and by offering a properly controlled referral system of workers to dentists.

RESOLUTION ADOPTED

At the April meeting a resolution was passed by the Society requesting that the government release to the profession certain needed instruments now that the demands of the armed forces are being met. Instruments sought include contra-angles, forceps, and surgical instruments.

In connection with this action it is interesting to note that a War Production Board notice within the past two weeks reports a new type of dental bur, with a chrome finish which will wear at least 50% longer than the steel type now in use, is now in production. Announcement of the intention to start production as soon as certain specialized machinery is available was made by the Dental Instrument and Bur Industry Advisory Committee. Output of dental bur has nearly tripled in the last three years, committee members said, and the industry is continuing to expand its facilities. However, military requirements have grown even more rapidly because of the

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These Need **NOT** Cause Trouble!

Very often dentures*, that have become loose and ill-fitting, do cause needless trouble. The wearer can experience such frequent embarrassment that a highly nervous state is developed. In some cases, insufficient mastication contributes to poor digestion.

Dr. Wernet's Plate Powder, sprinkled on dentures, holds them securely and comfortably in place —cushions the shock of biting and chewing and thereby helps to restore confidence and the ability to masticate all types of food properly.

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**Loose, ill-fitting dentures are usually the result of changed bone and tissue formation. In severe cases the patient should, of course, see his dentist.*

DR. WERNET'S POWDER

Holds dentures firmly and comfortably in place



DENTAL NEWS

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possibility of loss or damage involved in shipments made to combat areas and use under war conditions.

DR. RACICOT NAMED CHAIRMAN

At the April meeting of the Board of Trustees of the Society, Dr. Dring announced the appointment of Dr. George Racicot of West Warwick as the chairman of the Clinic Committee for 1944. Under a new plan adopted by the Board the member of the Board next to go into office becomes chairman of the Clinic Committee for the year.

TUFTS NEW DENTAL SCHOOL

Plans have been drawn for a new Dental School and a goal of $300,000 has been set in a campaign for funds to erect a new building. It will be part of the New England Medical Center in downtown Boston. Besides the most modern facilities for undergraduates, there will be greater opportunities to provide refresher courses and post-graduate study for alumni, thus fulfilling the obligation of Tufts to New England society and to dentistry as a whole.

A D A COUNCIL ON DENTAL THERAPEUTICS — REPORTS

The Council recently voted, after discussing all available evidence, that ultra-violet disinfecting lamps, as *presently* promoted for use in dental practice, be declared unacceptable; full report to be published.

The Council warns against routine use of substances containing fluorides because of questionable value at present and possible deleterious effects.

The Council approves use of sulfonamides in form of sterile powders for topical application; complex ointments or packs not approved.

"Glucaine"—not acceptable.

"Forhans Toothpaste"—its only value is as a not unpleasant adjunct to the toothbrush in cleaning teeth; its advertising constitutes acts and practices injurious to the public, according to complaint of Federal Trade Commission.

"Effremin Dentifrice"—claims of reducing sensitivity, controlling decalcification alleged false and misleading by government.

4% Procaine solutions—not acceptable; neither necessary nor desirable.

IT'S YOUR JOURNAL

When the Rhode Island Medical Society made its *Journal* available to the dental profession it generously listed the *Journal* as the official publication for our Society. This action places a corresponding responsibility upon us to make the dental contributions outstanding each month. Every member is urged to assist by submitting articles for publication on technical subjects, or by sending in news items worth reporting to the entire profession of the State. All such contributions should be sent to the Editor of the dental section.

DENTAL CORPS ANNOUNCEMENTS

(Addresses of R. I. Members)

Lt. Gerard P. Archambault, DC, Naval Base, Fishers Island, New York.

Capt. Jacob Biderman, DC, Station Hospital, Hunter Field, Georgia.

Lt. Edward Brown, DC, 1550th S U D C No. 3, Station Hospital, Fort Knox, Kentucky.

Lt. (jg) Leroy Fishman, DC, USNR, U. S. Marine Air Station, Pollocksville Field, New Benu, North Carolina.

Lt. A. Alfred Goldberg, DC, Naval Air Station, Quonset Point, Rhode Island.

Capt. Raymond Lapolla, DC, Station Hospital, Camp Mackall, North Carolina.

Lt. Burton Litchman, DC No. 2, Station Hospital, Fort McClellan, Alabama.

Lt. (jg) Milton Marks, DC, USNR, Naval Recruiting Station, Casco Bay, Portland, Maine.

Capt. Daniel J. Meliff, DC, APO 564, c/o Postmaster, New York, N. Y.

Capt. Michael B. Messore, DC, Med. Det., Station Hospital, Hunter Field, Savannah, Georgia.

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ARTHUR H. RUGGLES, M.D., *Editor*

The President of the Hospital Association of Rhode Island has asked me to serve as Editor of this section of the RHODE ISLAND MEDICAL JOURNAL. It is a pleasure to be of help in this capacity. I shall have to depend a great deal upon Mr. Francis C. Houghton, the able secretary of the Hospital Association, for help in the details of gathering material for this section, and upon all of you who are connected with the Hospital Association for items of interest from your respective hospitals. I feel that with your cooperation the members of the Rhode Island Medical Society can be informed of what is going on in the various hospitals of our State, and the hospitals themselves can better publicize their varied activities. I trust that this section may serve a doubly useful purpose in this way.

ARTHUR H. RUGGLES, M.D., *Editor*

BUTLER HOSPITAL CENTENNIAL

Butler Hospital, the oldest in Rhode Island, on May 10th celebrated the One Hundredth Anniversary of its founding at a meeting in Ray Hall at the Hospital. About 450 invited guests, drawn principally from the fields of psychiatry, general medicine, nursing, and social welfare organizations, listened to remarks by Mr. Walter A. Edwards, President of the Board of Trustees, and Mr. John Nicholas Brown, great-grandson of the original benefactor of the Hospital and Chairman of the Centennial Committee of Arrangements. Dr. Arthur H. Ruggles, Superintendent of the Hospital, introduced four nationally known psychiatrists, each of whom gave thirty minute addresses. Dr. Edward A. Strecker of Philadelphia, President of the American Psychiatric Association, spoke on "The Contribution of Psychiatry to Democratic Morale"; Dr. Gregory Zilboorg of New York, Associate Editor of the Centenary Volume of the American Psychiatric Association, discussed "Psychiatric Problems in the Wake of the War", during the afternoon session. After a buffet supper in the Kane Gymnasium the session was reconvened at 7:00 P. M. to listen to Dr. Karl A. Menninger of Topeka, Kansas, who spoke on "The War Against Fear and Hate".

Miss Anna K. McGibbon, R.N., Superintendent of Nurses at Butler Hospital, introduced Miss Elizabeth S. Bixler, Professor of Nursing at the Yale University School of Nursing, who addressed the group on "The Contribution of Psychiatric Nursing to Nursing Education". The concluding address of the evening was given by Dr. Alan Gregg, Director of the Division of Medical Sciences of the Rockefeller Foundation, New York City, on "The Place of the Endowed Hospital in the Future".

An historical volume entitled "A Century of Butler Hospital 1844-1944", written by Mr. William G. Roelker, Director of the Rhode Island Historical Society, Dr. Arthur H. Ruggles, and Dr. Gregory Zilboorg, was presented to each invited guest as a momento of the occasion.

Elizabeth S. Bixler, Professor Nursing at the Yale

PECK ESTATE CEDED TO HOSPITAL

Former State Finance Commissioner Frederick S. Peck and Mrs. Peck recently donated their magnificent estate at Barrington, known as Belton Court, to the HOMEOPATHIC hospital to be used as the Board of Trustees decide. Mr. Peck, president of the hospital board of trustees for the past 16 years was recently succeeded by Henry G. Clark. In accepting the gift of the Peck mansion, several other buildings and 100 acres of adjoining land, the hospital trustees indicated that it will be admirably adapted for use as a convalescent home or a children's hospital.

Belton Court, one of Rhode Island's most beautiful estates, overlooks the Barrington river, and it

continued on next page

ASSOCIATION MEETING

The semi-annual meeting of the Hospital Association of Rhode Island will be held at Rhode Island Hospital at 3 P. M. on Thursday, June 22.

HOSPITAL NEWS

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consists of a two story granite structure with a tower rising from its northeast corner. Features of the mansion are a huge ballroom, a large dining room used only for formal occasions, and a large library. Lying between the main part of the house and the wing is an elm-shaded courtyard with a pool.

Describing the gift as "extremely timely" in view of the overcrowded conditions at the hospital, Mr. Clark, president of the board, stated that Belton Court might well be integrated into the building plans for the future development of the hospital.

GOV. McGRATH ADDRESSED TRI STATE ASSEMBLY

By special invitation Gov. J. Howard McGrath addressed the Tri-State Hospital Assembly at their annual dinner in the Palmer House at Chicago on May 11th. He outlined the steps leading to appointment of the State-wide Voluntary Advisory Council on Health and gave a resume of the report of the technical committee of this organization. Rhode Island at the present moment is leading the way in the field of State Health programs. It behooves us all to follow this proposed program closely to the end that adequate health facilities may be provided to the residents of this State unhampered by partisan political activity.

DISTRIBUTION OF PENICILLIN

Penicillin, the latest great tool of the medical profession is now available in limited quantities for use in Civilian Hospitals. A recent communication from the War Production Board announces this fact and lists the rules which govern control and distribution of the drug. Various hospitals selected as depot hospitals are assigned quotas for each month. These hospitals must submit a monthly report showing amounts used or sold to other hospitals. Purchase orders from the depot hospitals must go to the Office of Civilian Penicillin Distribution. After approval, these orders are sent to a manufacturer who ships and bills the hospital in the usual manner.

The depot hospitals in Rhode Island are: Newport Hospital, Pawtucket Memorial Hospital, Homeopathic Hospital, Rhode Island Hospital, St. Joseph's Hospital and Westerly Hospital.

WALKING THE ROUNDS

Dr. H. P. Jordan reports that confinements at LYING-IN hospital show a decrease of 11% for the first period of this year as compared with the same period a year ago, and at the same time confinements under the EMIC plan have steadily increased so that at the present time 250 prospective mothers are booked for delivery during the next four months.

With 17 of its staff members with the armed forces HOMEOPATHIC hospital is utilizing the services of the pediatric staff of R. I. Hospital as those doctors have volunteered for the additional work—a splendid example of cooperative effort.

Since last October one floor of WESTERLY hospital has been closed and all patients, except maternity, accommodated on one floor in order to spare the nursing service. Since the Westerly area has an increased population in the summer the demands upon the hospital are expected to be acute, according to Miss Blaisdell, the superintendent.

NOTRE DAME hospital has announced the appointment of Miss Albina Varieur as superintendent to succeed Miss Martha DuTilly who has resigned.

RECORD LIBRARIANS MEET

This year the Rhode Island Association of Medical Record Librarians was privileged to have its annual meeting at the Rhode Island Medical Library on the morning of May 24th in conjunction with the Rhode Island Medical Society's Annual Meeting and honored to have two fine speakers. Dr. Herman C. Pitts gave an interesting talk on Abdomino-perineal Resection, and Dr. William A. Horan reviewed the principles of the Kenny Treatment, illustrating with moving pictures taken at the Charles V. Chapin Hospital during the 1943 epidemic.

Election of officers for the coming year was held with the following results:

President, Miss Gertrude Cahir, Rhode Island Hospital.

Vice-President, Miss Eleanor Murphy, Charles V. Chapin Hospital.

Secretary, Miss Olivia Brum, Emma Pendleton Bradley Home.

Treasurer, Miss Sarah Litwin, Miriam Hospital.

Applications for membership from Miss Magdalen Colston of the South County Hospital and Miss Delia Biron of the Rhode Island Hospital Tumor Clinic were read and accepted. After the business meeting all members present enjoyed a pleasant luncheon at the Crown Hotel.



IN THE *Progressive* NUTRITIONAL NEEDS OF GESTATION

While it is not strictly true that the gravid woman must "eat for two," nutritional requirements nevertheless are higher during pregnancy. As the fetus increases in size, its nutritional demands increase. In consequence, food consumption must be progressively raised to prevent catabolic breakdown of maternal tissue to satisfy these needs.

Ovaltine proves of real value as an aid in satisfying the greater nutritional needs during pregnancy. This delicious food drink proves appealing during this period when anorexia may seriously curtail food consumption. It supplies the nutrients especially required for proper fetal growth—minerals, vitamins, and biologically adequate proteins. Prescribed during the second and third trimesters, Ovaltine helps promote a state of optimum nutrition in the mother and optimum development of the fetus.

THE WANDER COMPANY, 360 North Michigan Avenue, Chicago 1, Illinois

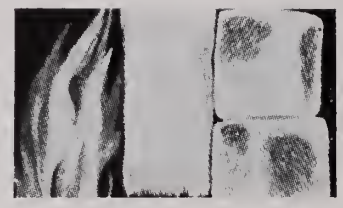


Ovaltine

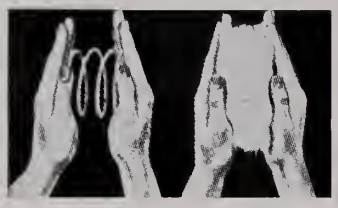
Three daily servings (1½ oz.) of Ovaltine provide:

	Dry Ovaltine	Ovaltine with milk*		Dry Ovaltine	Ovaltine with milk*
PROTEIN	6.0 Gm.	31.2 Gm.	VITAMIN A	1500 I.U.	2953 I.U.
CARBOHYDRATE	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
PHOSPHORUS	.25 Gm.	.903 Gm.	NIACIN	3.0 mg.	5.0 mg.
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg.

*Each serving made with 8 oz. of milk; based on average reported values for milk.



Glass that doesn't burn or conduct heat . . .



Glass that is springy. And as insulation . . .



. . . is unchanged by time—doesn't decay.

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THERE'S A different kind of glass in the world . . .

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. . . but glass in the form of fibers—glass that is finer than human hair.

This unusual glass—Fiberglas*—is soft, pliant. Threads of Fiberglas are woven into fabrics having many uses. Or, other fibers are formed into a soft, wool-like mass and used as insulation against heat. Or, it is felted, compressed, and formed into pipe coverings and insulating boards.

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Fiberglas can be used in a thousand places where glass was never used before! It does the specific job of other materials . . . *and then adds the unique* advantages of glass!

Glass, in fiber form, has great tensile strength. It's springy. It can't burn, rot, mildew. It won't pick up moisture or odors from the air. It resists most acids. Moths, termites, rats, vermin won't eat it. And it gives these extra advantages wherever it is used.

No wonder dozens of industries are already using 117 forms of Fiberglas . . . both in war and civilian goods!

This page pictures some ways that the "wool" form of Fiberglas protects you, or medical supplies, or food for fighters, from heat or cold. For more information about Fiberglas, write for free booklet, "Fiberglas, a New Basic Material." *Owens-Corning Fiberglas Corporation, Toledo 1, Ohio. Fiberglas Canada, Ltd., Oshawa, Ontario.*

FIBERGLAS
*T. M. Reg. U. S. Pat. Off.





Insulated food containers in this truck bring hot meals to troops in a forward area. Rough roads and rough handling shake up the containers. Yet they remain efficient, because Fiberglas insulation is springy—does not settle under vibration.



Army uses domestic refrigerator for blood bank in evacuation hospital. Fiberglas insulation helps keep blood at correct low temperature under extreme conditions of heat, rain, and knocking about . . . Fiberglas will not rot, mildew, or support fungus growth.



In the postwar world, Fiberglas insulation will bring its extra advantages to the new field of frozen-food cabinets. For these units must keep food frozen at low cost. Fiberglas permits the control of temperatures efficiently and economically.



Manufacturers of domestic ranges have interesting developments on the way. All point toward better, more convenient and economical cookery. And, again, Fiberglas insulation will play its important part in better living.

FIBERGLAS—A NEW BASIC MATERIAL

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

Charles L. Farrell, M.D., *Chairman*; Stanley Davies, M.D.; Arthur E. Martin, M.D., Elihu S. Wing, M.D., William P. Buffum, M.D.

PRE-EMPLOYMENT EXAMINATIONS FOR WOMEN

Pre-employment physicals of women in industry do not usually include a pelvic examination.

The desirability of such an examination is apparent when it is considered that millions of women are now employed at many tasks formerly performed by men. When it is further considered that a large number of these women are married and have children it becomes almost imperative that pelvic disorders be recognized if such women are to be properly placed in industry. The literature on this subject is extremely meagre. Therefore the report of Dr. Forrest E. Gibson, Medical Supervisor of the Hamilton Standard Propellers Division, United Aircraft Corporation, as published in Industrial Medicine for April, 1944 is extremely timely and well worth careful study.

Most industrial physicians avoid the subject of pelvic examinations in women because they claim there will be too much objection to it on the part of prospective workers. In this connection it is interesting to note that in Dr. Gibson's series 410 women were offered the opportunity for pelvic examination and only 3 refused it.

The gynecologic examinations were limited to married females who had had children or gave histories suggesting pelvic pathology. The women examined represented 27% of the parous female applicants and only 35.1% of these presented no disorders. Thus 64.9% had significant pathology.

Cervicitis was present in 40.5% of the women examined and this represented 50.6% of the total defects. An infected cervix is certainly a definite source of trouble and in an industry employing a large number of women the presence or absence of cervicitis should make a great deal of difference in absenteeism. Like any other foci of infection it can oftentimes be a forerunner of many and more serious defects causing ill health and loss of time.

It is interesting also to note a large incidence of cystocele, rectocele and prolapsed uterus. This occurred in 30.7% and in turn represented 38.3% of the total defects.

Industrial physicians in plants employing a large number of women, particularly where female employees have to lift weights, should give serious consideration to pelvic examinations, particularly so if women have to go through an extensive training period prior to their employment. It is disconcerting to train a woman for a job and then to find out afterwards that she is unable to do it—totally unfitted physically for the work for which she was trained.

With the increased attention paid to physical examinations in industry, with the ever expanding field of industrial health, it is to be fervently hoped that pelvic examinations will become a regular part of pre-employment examinations.

SYPHILIS IN INDUSTRY

Venereal disease in Rhode Island Industry is not a particularly serious problem. The most important aspect of any venereal disease control program, however, is case finding. One of the simplest means of case finding is industrial pre-employment wassermans. Industrial physicians are oftentimes reluctant to take wassermans for the same reason they are reluctant to do pelvic examinations. It has seemed that their pre-employment physical examinations are based mostly on the minimum possible work required to enable the prospective employee to be placed in a job. Nevertheless, if we are to

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INDUSTRIAL PHYSICIANS ELECT

At the first annual meeting of the Rhode Island Society of Industrial Physicians and Surgeons, held May 23, the following slate of officers was elected to serve for 1944-45:

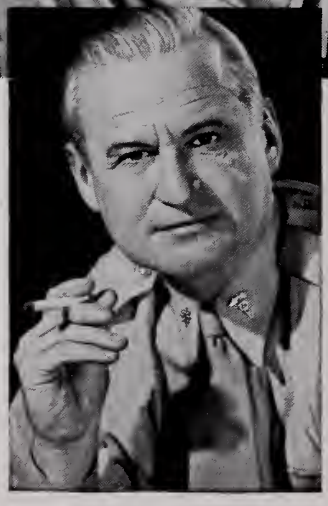
Charles L. Farrell, M.D. ..... *President*
Richard F. McCoart, M.D., *Vice President*
James P. Deery, M.D. ..... *Secretary*
Robert T. Henry, M.D. ..... *Treasurer*

(*Board of Directors, in addition to above*)
Thomas A. Egan, M.D., Frank A. Merlino, M.D., Remington P. Capwell, M.D., Edward F. Dougherty, M.D.

This is a Transfusion!

IN WAR, DRAINED MINDS NEED THEM, TOO





In modern war, fright, shock—no less than wounded flesh—sap fortitude, shrink staying power. Restoring fighters' morale is a constant concern of the military doctor. Whether under front-line fire or sheltered in a base hospital, he knows the lift of a friendly smile, a helping hand—a cheering talk over a cigarette. A Camel, most likely, the first choice of service men* for the real mildness and that deeply appreciated flavor.

It's a busy life for the medical officer... and a tough one. He too appreciates precious moments of relaxation... with a Camel.

1st in the Service

*With men in the Army, Navy, Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)



Camel COSTLIER TOBACCOS

BUY WAR BONDS STAMPS

New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

DOCTORS AT WAR

VISITORS AT STATE MEETING

Proximity in assignment to stations near Providence, as well as furloughs that permitted returns home enabled several of our members in the armed forces to attend some of the sessions of the 133rd annual meeting. Among those registering were Comdr. William P. Davis, MC, USNR, chief of surgery at the Quonset Air Station, recently promoted Lt. Comdr. Walter F. Fitzpatrick, MC, USN, now stationed at Newport Naval Hospital after six months' work at the Mayo Clinic, Major Jeremiah A. Dailey, MC, now located at the new Cushing General Hospital at Framingham after a long tour of duty in the Pacific theater, and Captain Edward Seltzer, MC, home on furlough from Camp Livingston, La.

RECENT ENLISTMENTS

Dr. John W. Helfrich, Westerly physician, recently enlisted as a Lieutenant Commander and was assigned to the Naval Training Station at Newport, while Dr. Linus Sheehan has been commissioned a Lieutenant in the Army and stationed at Valley Forge General Hospital in Pennsylvania.

NEWS FROM ABROAD

A message from Captain Richard Arlen, MC, informs us that he is now a flight surgeon with a tactical reconnaisance squadron in the 9th Air Force some of whose pilots are from the famous Eagle squadron. He reports receiving the Medical Journal regularly and he finds it a great help in keeping him posted on the events and happenings in these Plantations.... We have heard that Lieut. Raymond Luft, MC, USNR, and Lieut. Thomas L. O'Connell, MC, USNR, have made the trip across the Atlantic and are now stationed in the British Isles.... It is Major Robert Murphy, MC, now, as word has come from India of the promotion within the past month.... After 18 months in the South Pacific Lt. Comdr. Amedeo Mastrobuono, MC, USNR, has returned to this country and is now assigned to the Naval Hospital at Chelsea.... Dr. Harold S. Barrett is now an assistant surgeon with the U. S. Public Health Service, and he is serving on loan as director of the Yazoo County (Mississippi) Health Department. ... Lt. Comdr. Herman Marks, MC, USNR, has been home on leave after a year of duty as a flight surgeon in the Carribean area. He is now assigned to Jacksonville, Florida.

MILITARY ANNOUNCEMENTS

ASSIGNMENTS

Lt. (s) Reginald A. Allen, MC, USNR, Naval Dispensary, Washington, D. C.

Lt. Raymond Luft, MC, USNR, c/o Fleet P. O., New York, N. Y.

Lt. Comdr. John W. Helfrich, MC-V(S), USNR, U. S. Naval Training Station, Sachuest Point Rifle Range, Newport, R. I.

Lieut. Linus A. Sheehan, MC, Valley Forge General Hospital, Phoenixville, Pennsylvania.

Capt. Joseph E. Wittig, MC, Carlisle Barracks, Carlisle, Pennsylvania.

TRANSFERS

Capt. Richard S. Arlen, MC, APO 595, c/o Postmaster, New York.

Major Abe A. Brown, MC, Veterans Hospital, Dearborn, Michigan.

Lieut. Harry E. Darrah, MC, 0-542997, 141st General Hospital, Kennedy General Hospital, Memphis, Tennessee.

Comdr. F. Charles Hanson, MC, USNR, c/o Fleet Records Office, San Francisco, California.

Capt. Emil A. Kaskiw, MC, 1621 S. U., Station Hospital, Fort Custer, Michigan.

Capt. Morris Botvin, MC, APO 928, c/o Postmaster, San Francisco, California

Lieut. Maurice N. Kay, MC, 54th Field Hospital, Fort Bragg, North Carolina

continued on next page

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THAT'S
JOHNNIE WALKER



BORN 1820
Still going strong

Its unrivaled smoothness and distinctive flavour makes Johnnie Walker a leader among scotches.

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JOHNNIE WALKER



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SCOTCH WHISKY

RED LABEL
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Both 86.8 Proof

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New York, N. Y.
Sole Importer

BUY UNITED STATES WAR BONDS AND STAMPS

CAPT. ADELE C. KEMPKER, MC, Lawson General Hospital, Atlanta, Georgia

LIEUT. WILLIAM A. REID, MC, O'Reilly General Hospital, Springfield, Missouri

LT. FREDERICK R. RILEY, MC, USNR, c/o Fleet Post Office, San Francisco, California

LT. COMDR. H. FREDERICK STEPHENS, MC, USNR, Cherry Point, North Carolina

CAPT. GEORGE L. WADSWORTH, MC, APO 230, c/o Postmaster, New York, N. Y.

LIEUT. ALFRED E. KING, MC, La Garde General Hospital, M.D.R.P., New Orleans, Louisiana.

LIEUT. GUSTAVO A. MOTTA, MC, 312th Med. Bn., 87th Inf. Div., APO 448 Fort Jackson, South Carolina.

LIEUT. WILLIAM A. REID, MC, Camp Phillips, Salina, Kansas.

CAPT. RICHARD D. RICE, MC, 0-471915, c/o Postmaster, San Francisco, California.

LT. EDWARD F. RUHMANN, MC, USNR, c/o Fleet Post Office, New York, N. Y.

CAPT. FRANCIS E. TEMPLE, MC, APO 308, c/o Postmaster, New York, N. Y.

LT. WILLIAM H. TULLY, MC, USNR, c/o Fleet Post Office, San Francisco, California.

PROMOTIONS

CAPTAIN WALTER E. BATCHELDER to Major.
LT. (S) WALTER FITZPATRICK to Lt. Comdr.
CAPTAIN ROBERT MURPHY to Major.
LIEUT. RICHARD BARONIAN to Captain
LIEUT. PHILIP S. GELLER to Captain
LIEUT. CHARLES E. MILLARD to Captain

SYPHILIS IN INDUSTRY

continued from page 289

make a complete physical examination, with the idea of evaluating the person's ability to do a particular type of work, it is essential that a blood, urine and oftentimes pelvic examinations be made.

In the Collyer Insulated Wire Works of Pawtucket, routine wassermans have been performed on every pre-employment examination since October, 1942. In only one case has there been any objection and out of 1175 people examined only 35 or 0.033% were found to be positive. In every instance these cases were non-infectious and employable but follow-up has been insisted upon. They have been referred to their family physicians and the employee and the family physicians are both checked at quarterly or six months' intervals to see that the patient is still under treatment and is still non-infectious.

The trail has been plainly marked. Pre-employment pelvic and pre-employment wassermans can and should be done. Let us hope that more physicians will incorporate them in their routine pre-employment examinations.

DISTRICT SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, May 1, 1944. The meeting was called to order at 8:35 P. M. by Albert H. Jackvony, M.D., President.

There being no objection, the reading of the minutes of the previous meeting was omitted.

The Secretary reported that the Executive Committee recommended for election to active membership in the Association Dr. Carl Steven Sawyer and Dr. Raymond H. Trott. Dr. Jesse E. Mowry moved the unanimous election of both doctors. The motion was seconded and passed.

The President announced that the Association's tribute to the late Dr. William McGuirk had been prepared by Dr. Michael J. Nestor and Dr. William Hindle and had been filed with the Secretary as part of the permanent records.

The President announced that three exhibitors were guests of the Association and would be pleased to talk with the doctors in the Reading Room. These exhibitors were Mr. William Dunlop representing Burroughs Wellcome Company, Mr. Fred Goulding, representing E. R. Squibb & Sons, and Mr. Anthony Celluzza, representing Abbott Laboratories.

The President called attention of the membership to the fact that the meeting was a joint meeting with the Children's Heart Association of Rhode Island and he then proceeded to introduce the guest speaker of the evening, Dr. Paul D. White of Boston, who spoke to the topic "The Problem of Rheumatic Fever and Rheumatic Heart Disease As We Face It In the Spring of 1944".

Dr. White gave a general and interesting talk on rheumatic fever. He stated that it is a wide-spread problem, being important even in Mexico which previously was considered to have an ideal climate for rheumatic fever sufferers. The Army is finding many patients and is establishing a hospital for taking care of them. Dr. White stated if you could elminate homolytic streptococci, you probably would do away with most rheumatic fever. Repeatedly, epidemics of rheumatism have followed in the wake of epidemics of the streptococcic infection.

Various experiments are somewhat effective in keeping rheumatism sufferers away from streptococci. If they are hospitalized in an isolated place away from cities and visitors kept out, a definite benefit is obtained. Dr. White commented on the value and limitations of regular sulfonamide ingestion during the winter months. The definite influence of social and economic status was discussed. Therapy by salicylates, etc., was considered.

The occurrence of chorea may indicate that cardiac involvement is not likely to occur. Dr. White did not recommend routine tonsillectomies but thinks the question should be considered on its own merit as in non-rheumatic patients. He favored pre-operative sulfadiazine in cases of tonsillectomy and tooth extraction. He believes that a slight degree of rheumatic heart disease does not prevent health and is not incompatible with the return of the soldier to active duty.

Great interest in Dr. White's talk was evidenced by the large number of questions asked from the floor.

After Dr. White's address the President showed a motion picture on the "Treatment of War Burns" prepared by John M. Converse, M.D., of the American Hospital in Britain.

While Dr. White was addressing the meeting a statewide blackout was conducted, but it was possible to continue the address in the semi-darkness of the hall.

The meeting adjourned at 10:25 P. M.

Collation was served.

Attendance 190.

Respectfully submitted,

FRANK W. DIMMITT, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

A regular meeting of the Newport County Medical Society was held at Newport on Tuesday night —May 2, 1944 at 8:30 P. M. Dr. Charles Dotterer, President, presided.

continued on next page

Vacation Days!

THE SUMMER RECESS FROM SCHOOL is more than just a time of continual play. It is the major opportunity you have to further the development of sound bodies — to build for good health in the years ahead.

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NEWPORT MEDICAL SOCIETY

continued from page 293

There was no unfinished business and there were no reports of committees.

The following communications were received:

(1) A letter was received from American Red Cross asking if any physician would be interested in doing Medical work for Veterans Administration. Usual office fee being $2.00, home visits being $3.00 and examinations whenever requested being $5.00.

A motion was made by Dr. Tartaglino to contact Red Cross for further information. It was seconded by Dr. L. Abramson and passed.

(2) A communication was received from the executive office of the Rhode Island Medical Society relative to a library file of topics available to physicians who are to give radio or public addresses. The communication was read and placed on file.

(3) A sympathy card was received from the family of Mrs. James J. Callahan and accepted.

The application of Dr. William C. Sloane, U.S.P.H.S. Reserve, was received and referred to the Board of Censors.

The question of a new fee schedule was brought up by Dr. Alfred Tartaglino and the various members gave their views. It was learned from Society records that the present fee schedule has been in effect since Sept. 10, 1918.

Dr. Alfred Tartaglino made the motion that starting May 15, 1944, the minimum fee for office visits shall be $3.00, the minimum fee for house calls shall be $4.00 between the hours of 8 A. M. and 11 P. M. while the minimum fee for house calls between 11 P. M. and 8 A. M. be $5.00. It was seconded by Dr. Abramson and unanimously passed by the members.

The meeting adjourned at 10:30 P. M. and was followed by a collation.

PHILOMEN P. CIARLA, M.D., *Secretary*

NECROLOGY

WILLIAM BRYANT CUTTS, M.D.
of Providence
Died, May 24, 1944

NATHANIEL H. GIFFORD, M.D., of Providence
Died, May 25, 1944

LOST
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Red Blood Cells Daily

Normally, the hematopoietic system is charged with the replacement of an estimated trillion red blood cells that are lost daily! The bone marrow must counteract this internal blitzkrieg. It must have raw materials: iron, protein, vitamin B-complex, the "anti-pernicious anemia factor," etc.

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Each fluid ounce of Hemo-Vitonin contains:

Alcohol, 14%
Liver Concentrate equivalent to 50 grams Fresh Liver
Vitamin B_1 (Thiamin Chloride), 218 Int'L Units
Vitamin B_2 (Riboflavin), 340 Gamma
Vitamin B_6, 220 Gamma
Pantothenic Acid, 1.2 Milligram
Nicotinic Acid, 8 Milligrams
Colloidal Iron Peptonate, 6.5 Grains

Dosage: Children, 1 teaspoonful 3 or 4 times a day. Adults, 2 teaspoonfuls 3 or 4 times a day.

Packages: Eight ounce and gallon bottles.

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PROVIDENCE

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held on May 18, 1944

WILLIAM P. BUFFUM, M.D., *Secretary*

A REGULAR MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Thursday, May 18, 1944. The meeting was called to order by President Michael H. Sullivan at 8:30 P. M.

The Secretary read the minutes of the previous meeting of the House of Delegates. Dr. Jesse E. Mowry moved that the minutes be approved as reported and placed on file. The motion was seconded and passed.

Dr. William P. Buffum, Secretary, gave his Annual Report for the year. Dr. Emery M. Porter moved that the report be accepted and placed on file.

Dr. Jesse E. Mowry, Treasurer, presented his annual report. Dr. Henry E. Utter moved that the report be received and placed on file.

The reports of the following committees were presented by the Chairmen and were accepted and placed on file: Committee on Publication, Committee on Medical Economics, Committee on Social Welfare, Committee on Legislation, and Committee on War Participation.

The slate of officers as proposed by the Council and recommended to the House of Delegates was read by the Secretary. The President called for a motion electing the slate of officers proposed. The motion was made, seconded, and passed.

The Secretary reported briefly on the most recent meeting of the Council of the Society. He stated that Dr. Elihu S. Wing had reported a balance of $102.51 in the Charles F. Gormly Fund and the recommendation made by the Librarian of the Society that this balance be utilized by the Library Committee for the purchase of books on Legal Medicine for the Library and that all such books be marked with a plate attesting to the fact that they form part of the Charles F. Gormly collection had been adopted. The Secretary moved that the House of Delegates endorse this action of the Council. The motion was seconded and passed.

The Secretary reported that the Council had recommended that contraceptive advertising be henceforth eliminated from the RHODE ISLAND MEDICAL JOURNAL. He moved that the House of Delegates adopt this recommendation. The motion was seconded and passed.

The Secretary reported that Dr. Herman C. Pitts, Chairman of the Committee on Medical Economics, had reported to the Council relative to the recommendations of the State Advisory Council on Health and that he had asked whether it was desirable that the Society make a study at this time of voluntary medical and surgical insurance to be administered through the Society. The Secretary reported that the Council had adopted a motion requesting that the Committee on Medical Economics and such additional members of the Society as the Chairman of that Committee may desire to enlist, prepare suggestions for the House of Delegates regarding voluntary insurance plans for the distribution of the cost of medical and surgical care in Rhode Island. The Secretary stated that no action would appear necessary on the part of the House of Delegates at this time pending a report from the Committee on Medical Economics at a subsequent meeting.

Dr. Elihu S. Wing discussed briefly his proposal for a system of councils as a solution for some of the present day health problems. The Secretary reported that the Council of the Rhode Island Medical Society planned to consider Dr. Wing's plan at its next meeting and that subsequent to that study a report would be made to the House of Delegates.

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SLATE OF OFFICERS AND STANDING COMMITTEES ELECTED BY THE HOUSE OF DELEGATES TO SERVE THE RHODE ISLAND MEDICAL SOCIETY IN 1944-45

President—ELIHU S. WING, M.D., Providence
Vice Pres.—FENWICK G. TAGGART, M.D., E. Greenwich
Pres. Elect—JOHN F. KENNEY, M.D., Pawtucket
Secretary—WILLIAM P. BUFFUM, M.D., Providence
Treasurer—JESSE E. MOWRY, M.D., Providence
Assistant Sec.—ALFRED L. POTTER, M.D., Providence
Assistant Treas.—CHARLES J. ASHWORTH, M.D., Providence

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Chairman—WILLIAM H. FOLEY, M.D.
EARL F. KELLY, M.D. JOSEPH L. BELLIOTTI, M.D.

Committee on Publication
Chairman—HAROLD G. CALDER, M.D.
AUGUSTINE W. EDDY, M.D. PAUL APPLETON, M.D.

Committee on Medical Education
Chairman—JESSE P. EDDY, 3RD, M.D.
G. RAYMOND FOX, M.D. JAMES MCCANN, M.D.

Committee on Medical Economics
Chairman—HERMAN C. PITTS, M.D.
LUCIUS C. KINGMAN, M.D. ALEX M. BURGESS, M.D.

Committee on Industrial Health
Chairman—CHARLES L. FARRELL, M.D.
STANLEY DAVIES, M.D. ARTHUR E. MARTIN, M.D.

Committee on Arrangements
Chairman—EDWARD F. BURKE, M.D.
CHARLES O. COOKE, M.D. CHARLES PHILLIPS, M.D.
JULIANNA R. TATUM, M.D. CHARLES BRADLEY, M.D.

Committee on the Library
Chairman—HERBERT C. PARTRIDGE, M.D.
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HOUSE OF DELEGATES REPORT

continued from page 297

The Secretary reported the following resolution received from the Executive Committee of the Providence Medical Association:

WHEREAS there has been presented to the General Assembly from time to time proposed legislation affecting the health of the citizens of this State, and

WHEREAS some of this proposed legislation has been passed by either or both branches of the Assembly without any opinion of its merit by the State Department of Health, and

WHEREAS the State Department of Health is duly bound by the statutes of the State to take cognizance of the interests of life and health among the citizens in all phases of activity, therefore be it

RESOLVED that the State Department of Health be urged by the House of Delegates of the Rhode Island Medical Society to take militant action henceforth in the investigation and study of all legislation introduced in the General Assembly relative to health in any of its ramifications, and also be it

RESOLVED that the State Department of Health be requested to express its opinions on all such legislation promptly to the General Assembly, and to the people of Rhode Island through the public press.

Dr. Buffum moved that this resolution be adopted by the House of Delegates. The motion was seconded and unanimously passed.

The Secretary presented the following resolution from the Providence Medical Association:

RESOLUTION ADOPTED BY THE PROVIDENCE MEDICAL ASSOCIATION AND SUBMITTED BY REQUEST TO THE HOUSE OF DELEGATES OF THE RHODE ISLAND MEDICAL SOCIETY

WHEREAS the House of Delegates of the American Medical Association has approved resolutions defining the relations of various medical specialties to hospitals, and has suggested that local medical societies take similar action, and

WHEREAS the Rhode Island Hospital Service Corporation at present does not include medical services in its contract, but there is a growing tendency in other states for the Hospital Service Corporations to have medical services included, therefore be it

RESOLVED: 1. That the Rhode Island Medical Society approves the dictum that the practice of Roentgenology and Anesthesiology is the practice of medicine just as is the practice of surgery or internal medicine.

2. That the Rhode Island Medical Society, with the House of Delegates of the American Medical Association, reiterates that it disapproves the injecting of a third party into the personal relationship of the patient and the physician, and that hospitals should not be permitted to practice medicine.

3. That the Rhode Island Medical Society does not approve of the proposed uniform comprehensive Blue Cross contract which includes certain medical services as a part of hospital care.

The Secretary moved the adoption of the resolution and Dr. Alfred L. Potter seconded it. The resolution was discussed by Dr. Adelson who questioned the reason for excluding Roentgenology and Anesthesiology from the hospital insurance contracts. Dr. Joseph L. Turner and Dr. Elihu S. Wing answered the questions raised by Dr. Adelson. The motion was unanimously passed and the resolution adopted.

The Secretary read a resolution received from the Secretary of the South Carolina State Medical Society relative to the distribution of the representation of delegates of the House of Delegates of the American Medical Association. It was moved to lay the resolution on the table. The motion was seconded and passed.

The Secretary read a resolution adopted by the House of Delegates of the Minnesota State Medical Association regarding the Maternal and Infant Care Program for Wives and Children of enlisted men and calling for the abandoning of the present program and the adoption of a new program to provide that the benefits be designated supplemental aid and that they take the form of an allotment for medical, hospital, maternity, and infant care similar to the allotments already provided for the maintenance of dependents, leaving the actual arrangements with the respect to fees to be fixed by mutual agreement between the enlisted man's wife and the physician of her choice.

This resolution was discussed by Dr. Buxton and by the Executive Secretary for the Society. After the discussion Dr. Buxton moved that the House of Delegates instruct its delegate to the American Medical Association to act on any resolution presented at the Annual Meeting of the American Medical Association relative to the E.M.I.C. program in keeping with the views already expressed by the Committee on Maternal Health in its report to the Rhode Island Medical Society. The motion was seconded and passed.

Dr. Elihu S. Wing reported on the proposal for a Chapin Oration Award to be made annually by the City of Providence to the speaker who delivers the oration at the Annual Meeting of the Rhode Island Medical Society. He read the City ordinance recently enacted relative to this matter. The Executive Secretary reported that he had met with the Committee of the City Council and they were to work out a design for a medal and they also planned that the first award should be given to Dr. Reginald Fitz who is to deliver the Chapin Oration before the Society on May 24th.

Dr. Gordon J. McCurdy raised the question of the present status of the Governor's proposal for hospital and medical care. Dr. Wing answered that the hospitalization program was still under consideration and that the Governor has asked the Society to study the possibility of a plan for medical and surgical care. Dr. Buffum called attention again to the fact that the Council has instructed the Medical Economics Committee to report to the House of Delegates at a subsequent meeting.

Dr. Emery M. Porter asked if the Curative Center problem is not a matter worthy of consideration by the Governor's Council. The opinion was expressed that the Governor's Council was free to discuss any problem concerned with the health of the Community.

The meeting adjourned at 10:00 P. M.

WILLIAM P. BUFFUM, M.D., *Secretary*

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ANNUAL REPORTS . . . 1944

ANNUAL REPORT OF THE SECRETARY

With the adoption of the revised By-Laws within the past year, and with the subsequent re-organization of the Society, the progress during the past twelve months has been outstanding.

In July, 1943, Mr. John E. Farrell, executive secretary of the Providence Medical Association for the previous five years, was installed as the executive officer also of the State Society. Through his office the activities of the Society have been better integrated, and the Society has rapidly assumed its rightful position in state medical and health leadership.

A membership drive during the year has had excellent support from the district societies, all of which have adopted the requirement that new members must belong to both the district and the State Society. The Providence Medical Association, our largest component unit, took an active part in our work of State Society enrollment, and as a result we now have a total of 706 members, 110 more than a year ago at this time, and the highest total in the history of the Society.

There are 175 members serving with the armed forces of the United States at the present time. During the past year 121 members joined the Society as Fellows, two members were re-instated, two resigned upon transferring from the state, and 11 members died.

The re-organized Council has held bi-monthly meetings at which there has been excellent attendance to discuss the many problems of interest to the medical profession of the State. Chairmen of various committees have been invited to the Council meetings to present reports from their groups, a procedure which has been most helpful in carrying out the mandates and policies of the Society.

Too much praise cannot be given to those doctors who have given so freely and willingly of their time and energy to meet in committees to answer problems of interest not alone to the profession but to the public at large. The annual reports of these committees indicate in but a small way the work that goes forward throughout the year.

The outstanding proposal of Dr. Emery M. Porter, in his presidential address to the Providence Medical Association, for a statewide voluntary council on health was approved by the House of Delegates which acquiesced in the appointment of this Council by the Governor. With the President of the Society as chairman, and with ten other members and also the executive secretary on this new Council, the viewpoints of the medical profession have been ably expressed, and a pattern has been set for the country in community planning for health.

WILLIAM P. BUFFUM, M.D., *Secretary*

REPORT OF THE BOARD OF TRUSTEES OF THE RHODE ISLAND MEDICAL SOCIETY BUILDING

The most important matter the Trustees have to report for the past year is the change in janitors. The Petersons decided to leave after service of eleven years. We were very sorry to have them go.

It was necessary to repaint the apartment before the new janitor's family came in. We also put asphalt tiling on the kitchen floor and rebuilt the china cabinet.

A second office was constructed from an alcove in the auditorium to provide desk space for Mr. Farrell's secretary.

There have been forty nine meetings held in the Library, including those of the Rhode Island Society of Industrial Physicians and Surgeons, to whom the courtesy of the use of the building was extended by vote of the Council.

JAMES L. WHEATON, M.D., *Chairman*

COMMITTEE ON CANCER

Your Cancer Committee has been rather inactive during the past year owing largely to the difficulty of finding proper personnel to carry out the program agreed upon at a meeting May 6, 1943 with the State Director of Health, Dr. Edward McLaughlin.

This program included two important things—First, the establishment of so-called Cancer Prevention Clinics as part of the State Cancer Control work. Their establishment is impossible without some competent Medical Man to organize and supervise them and so far no such man has been found.

The second thing is the development of a sound Educational Program on Cancer in our Secondary Schools. The ground work is being laid for this and we trust that before the schools open in the Fall a course can be laid out that will give the pupils a sound understanding of Cancer and the problems involved.

Your Cancer Committee has had at least two meetings as part of the Executive Committee of the Women's Field Army, R. I. Division and so has helped guide the activities of the very live body.

I wish to take this opportunity to apologize for the little we have accomplished this year and to put the blame squarely on the shoulders of the Chairman. The members of the Committee have always been most co-operative and will-

continued on next page

ANNUAL REPORTS

continued from preceding page

ing to go ahead. But alas, your Chairman has been frustrated in accomplishment by the pressure of a multitude of duties. HERMAN C. PITTS, M.D., *Chairman*

GEORGE W. WATERMAN, M.D., B. EARL CLARKE, M.D., ISAAC GERBER, M.D., JOSEPH C. O'CONNELL, M.D., PETER PINEO CHASE, M.D., FRANK E. McEVOY, M.D., G. RAYMOND FOX, M.D., WALTER C. ROCHELEAU, M.D., SAMUEL ADELSON, M.D., HARTFORD P. GONGAWARE, M.D.

COMMITTEE ON MEDICAL DEFENSE AND GRIEVANCE

The Committee has had two cases of threatened malpractice suits brought before it during the current year. In both instances Providence physicians were involved, and the members of the Committee on Ethics and Deportment of the Providence Medical Association were invited to take part in the hearings. Legal counsel representing the physicians was also present. The attendance was very gratifying. The entire personnel of the State Society Committee and a majority of the District Society Committee members attended the meeting which was held on a Sunday forenoon.

In both cases the two Committees were unanimous in the opinion that no error had been committed.

The Committee wishes to urge all Fellows who have cases in which a dispute has arisen which might lead to possible litigation, to report the circumstances to the Committee at the earliest possible moment, before any steps have been taken to institute legal proceedings.

ROLAND HAMMOND, M.D., *Chairman*

NORMAN S. GARRISON, M.D., JOHN E. RUISI, M.D., FENWICK G. TAGGART, M.D., JAMES L. WHEATON, M.D., ROBERT H. WHITMARSH, M.D.

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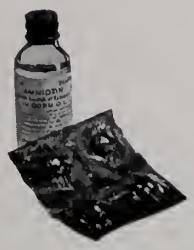


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[1] *Jl. Clin. Endocrinology* 3:648, Dec. 1943.

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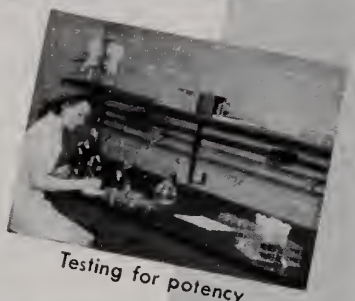
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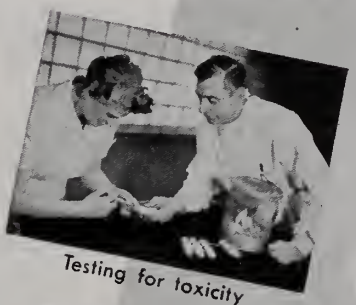
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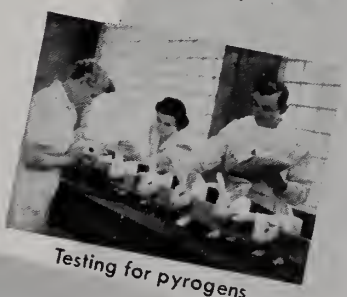
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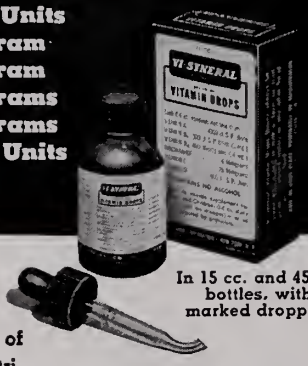
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COMMITTEE ON INDUSTRIAL HEALTH

The Committee held no formal meetings this year due to the difficulties of getting a mutually agreeable date and time. Problems relating to Industrial Health have been handled by your Chairman. Early in the year the War Manpower Commission met with the representatives of the Committee and solved the problem of health reports for Certificates of Availability.

Cooperation between your Committee and the War Manpower Commission has resulted in national recognition. Your Chairman attended the American Medical Association Council of Industrial Health Meeting in Chicago in February at which time he was requested to address the Meeting in reference to these War Manpower Certificates of Availability. This problem has plagued the other states and we have been besieged with requests from them for our solution to the problem.

Our surveys of the plants in the state, the compilation of data regarding Industrial Physicians and Nurses, and the plant medical facilities, has been completed. The Committee has in its files all data pertinent to Industrial Health in Rhode Island. We are prepared to serve industry, industrial nurses and industrial physicians in any capacity. Last year the Committee arranged an Industrial Health Institute with the cooperation of the Chamber of Commerce and Social Welfare Agencies. This year your Committee is cooperating with the Rhode Island Society of Industrial Physicians and Surgeons and Rhode Island Nurses Club in sponsoring a full day meeting at the Rhode Island Medical Library on May 23rd.

Inasmuch as no specific problem has been presented to the Committee or no formal routine of work has been outlined, the Committee has cooperated with the officers of the Rhode Island Society of Industrial Physicians and Surgeons, which it was instrumental in forming, to the end that Industrial Medical Practice will be placed on a higher plane—that nurses and physicians engaged in industry may have a forum in which they may discuss their problems and wherein they may meet to their mutual advantage. Industrial Medicine is assuming a larger and more important sphere in medical activities with each passing month, particularly, because of the war. The Committee has been instrumental in furnishing up to the minute material for the page devoted to Industrial Health published in the RHODE ISLAND MEDICAL JOURNAL monthly. In this connection we have received favorable comments from other state journals and particularly have been congratulated by the American Medical Association.

The Committee has been instrumental in cooperating with the Rhode Island Society of Industrial Physicians and Surgeons to the end that open forums have been held to discuss the feasibility of establishing a standard code of Industrial Medical Practice.

Your Committee has also been instrumental in furnishing the Library with additional reference books on industrial hygiene and in arranging for coverage for state activities in the National Magazine of Industrial Medicine.

In the absence of directives from the State Society the active program of furthering industrial health has been more or less relegated to the Rhode Island Society of Industrial Physicians and Surgeons. The Committee has contented itself with compiling statistical data and being ready for cooperation with interested parties and acting as a liaison group between Industry and Medicine.

CHARLES L. FARRELL, M.D., *Chairman*

HERBERT E. HARRIS, M.D., STANLEY DAVIES, M.D., MICHAEL H. SULLIVAN, M.D. (*ex officio*), WILLIAM P. BUFFUM, M.D. (*ex officio*).



COMMITTEE ON MATERNAL HEALTH

As in years past each death of a woman whose death return reports a puerperal condition as a primary cause of death or pregnancy as a contributing cause has been investigated by a paid investigator of the Department of Health who has reported his findings to this committee. The committee is unable at this time to make a detailed report of its findings.

It held several meetings to consider the Emergency Maternity and Infant Care Program of the Federal Children's Bureau of the Department of Labor. It approved a state plan submitted by Dr. Corrigan, Director of the Children's Bureau of the State Department of Health as the best program possible under the regulations imposed by the Federal Children's Bureau which is designated by Congress as the agency to administer the funds appropriated by Congress for that purpose. The committee has reported the results of its deliberations to the Council which approved its report and ordered it printed in the JOURNAL.

The committee sent a summary of this report to each Rhode Island Congressman pointing out the objections of the Rhode Island Medical Society to many features of the plan as at present administered. These letters were courteously acknowledged.

EDWARD S. BRACKETT, M.D., *Chairman*
BERTRAM H. BUXTON, M.D., IRA H. NOYES, M.D., ANDREW W. MAHONEY, M.D., MILTON GOLDBERGER, M.D., JOHN W. HELFRICH, M.D., HENRI E. GAUTHIER, M.D., JAMES C. CALLAHAN, M.D.

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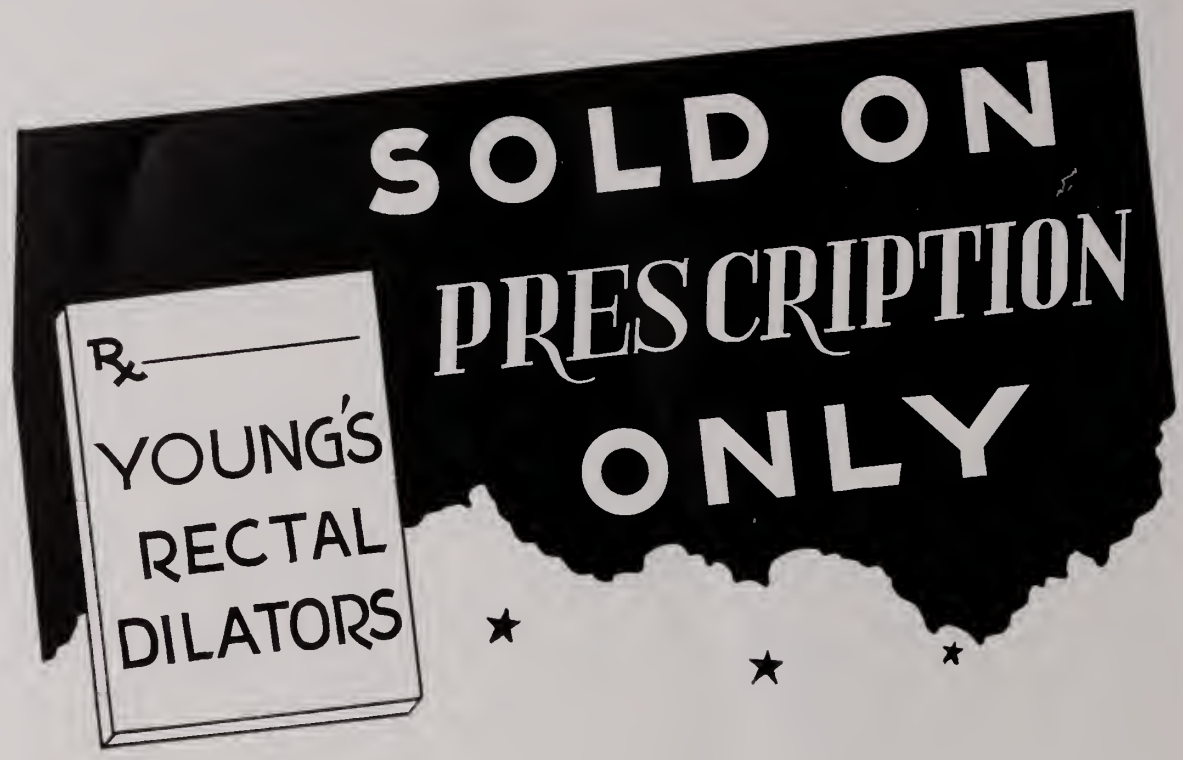
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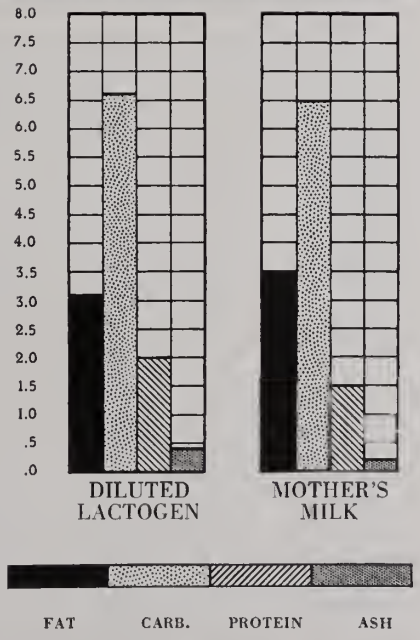
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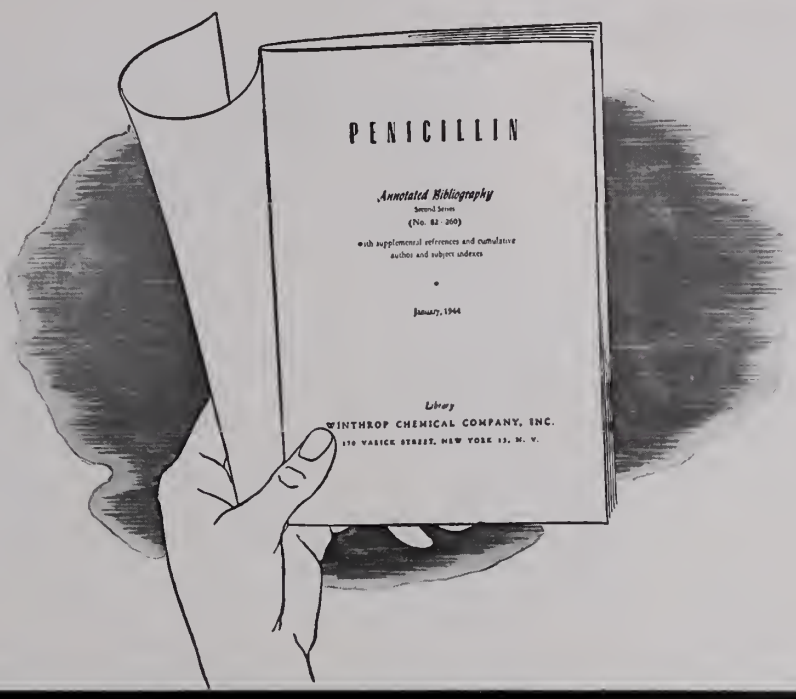
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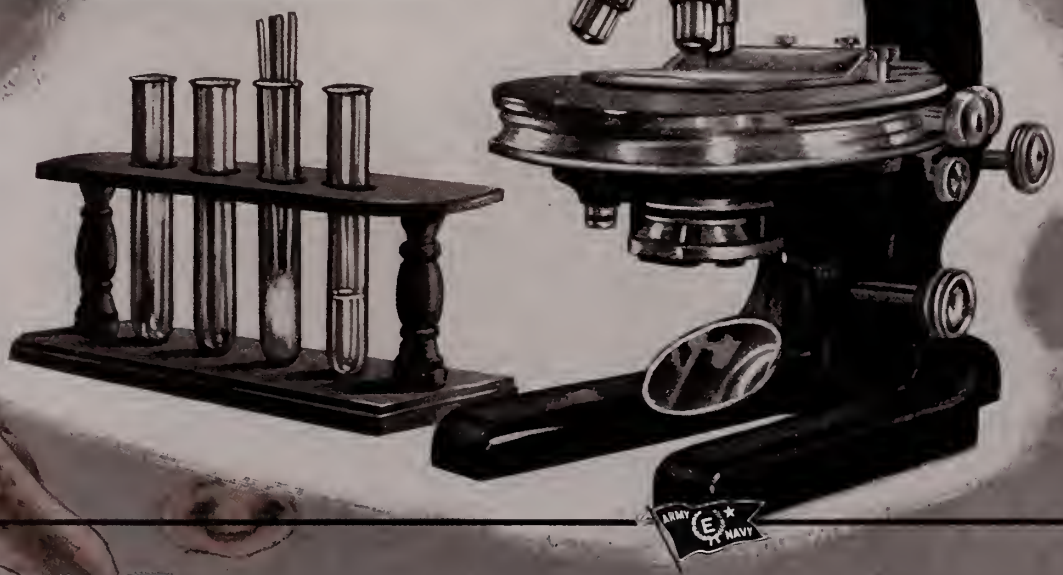
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVII JULY, 1944 No. 7

MALARIA*

J. B. RICE, M.D.

The Author. *J. B. Rice, M.D., of New York City. Director, Medical Research, Winthrop Chemical Company.*

UP to the present time the American medical profession has for the most part ignored the problems and diseases occurring behind the green wall which we call the "tropics". Some great and lasting contributions to the science of tropical medicine have been made by Americans but the great body of American physicians, preoccupied with their own problems, have not interested themselves in the diseases of hot climates. The reason for this apathy is, of course, obvious. America has no colonies in the tropics and, compared with even such small nations as Belgium, Portugal and Holland, American commercial and industrial interests in the tropics have not been large.

There are two important factors now at work which will bring about a change in American medical thought and interest in this respect. In the first place, air transport is rapidly shrinking the size of the earth to the point where it is not too great a stretch of the imagination to consider West Africa as a suburb of New York and some of the Pacific Islands as lying in the back yard of San Francisco. The second important factor is the war. In this global struggle American soldiers are already fighting in almost every corner of the world. In spite of the fact that they are protected by the finest medical service in military history, some of these soldiers have acquired tropical diseases and will bring them back to this country. Therefore, every American physician, regardless of where he is stationed in continental United States, may soon be compelled to take an active interest in tropical medicine.

It is important for us to recognize unfamiliar conditions when presented by returning travelers or soldiers. It is essential that we know the proper treatment and urgent that we are sufficiently familiar with the epidemiology of these diseases to prevent their spread to healthy individuals.

Malaria is without doubt the "King of Tropical Diseases" because in terms of human suffering and economic loss, no other disease approaches it in importance. Historically, it has played an important role in the progress of civilization. It has often been the determining factor in the outcome of wars. Many historians attribute the decline of Greek and Roman civilizations, in part at least, to the enervating effects of malaria on the populations. Malaria is the world's most widespread serious ailment. About one quarter of the inhabitants of the globe suffer from malaria. In India alone there are more than a million deaths each year due to this cause. In addition to being the world's most economically expensive disease, malaria is also probably the most interesting and complex disease because its manifestations are influenced by several varying factors. A mathematical equation with one variable is fairly simple. An equation with two variables, however, is far more than twice as complex, whereas an equation with three unknowns is beyond solution except by the expert mathematician. There are three varying factors in malaria: the mosquito vectors, the human hosts, and the parasites themselves.

The Vectors of Malaria

Malaria is transmitted by the great family of mosquitoes known as Anopheles. There are about 350 species of anophelines, all with different physical characteristics, behavior and habits, many of which are important in malaria. Fortunately, most anopheline species do not transmit malaria. About 90 species are capable of acting as vectors, but again, only about 12 or 15 are of prime importance. The following few species of Anopheles are responsible for the transmission of perhaps 90% of the world's malaria: *Anopheles quadrimaculatus* which is scattered over most of the United States, is responsible for the malaria in our south-

continued on next page

*An address delivered at the 133rd Annual Meeting of the Rhode Island Medical Society, at Providence, May 25, 1944.

ern states. *Anopheles albimanus* is the principal carrier in South America. In Europe most of the malaria is transmitted by the brackish water breeding *Anopheles maculipennis var. elutus**. In Italy another variety of *A. maculipennis,* that is, *labranchiae,* is an effective vector. Maculipennis mosquitoes are characterized by their great flight range. They will disperse for as much as five miles from their breeding places in sufficient numbers to produce epidemic malaria. *Anopheles superpictus* is responsible for epidemic malaria in Cyprus and the Near East. In Africa there are two good malaria carriers, *Anopheles gambiae* and *Anopheles funestus. Anopheles gambiae* is the most deadly and difficult to control of all anopheline vectors. *Anopheles minimus* is responsible for malaria in the Philippines and Malaya; it played an important part in bringing about the fall of Bataan. *Anopheles punctulatus* is the principal malaria carrier in the islands of the Pacific and northern Australia. In India there are two important vectors, *Anopheles culicifacies* and *Anopheles hyrcanus.*

In order to evaluate properly the likelihood of malaria spreading from any given focus of infection, it is necessary to know the species of Anopheles present in the particular area and to understand the reasons why one species can transmit malaria while another cannot. Several factors are involved.

To be able to transmit malaria, a mosquito must be a suitable host for the parasite, that is, its metabolic processes must not be inimical to the development of the parasite in its body. An interesting example is afforded by *Anopheles superpictus.* In the island of Cyprus, this anopheline is responsible for intense malarial transmission. In nearby Macedonia, although the temperature is only slightly lower, the life processes of this particular mosquito are so altered that it cannot act as an efficient carrier although the mosquito is present in large numbers. It bites malaria patients and develops an apparently normal infection in its stomach. However, when the oocysts in the stomach wall rupture and set free the sporozoites, which migrate to its salivary glands, some condition probably dependent on the cooler climate causes the sporozoites to degenerate to such an extent that they cannot infect a normal human being even though injected into such a person.

In order to transmit malaria, it is obvious that mosquitoes must bite human beings, inasmuch as human malarial parasites do not live in the bodies of lower animals. One of the reasons why *Anopheles gambiae* is the most efficient malaria vector known is because it bites only human beings. It has, therefore, the best chance of acquiring malarial infection; and once this is acquired, *gambiae* wastes none of its sporozoites on the lower animals.

It was a striking fact that in Greek Macedonia during the course of many thousands of mosquito dissections, no infected specimen of *Anopheles maculipennis var. typicus* was found, whereas the coexisting variety *elutus* showed a sporozoite rate of approximately 3%. An obvious explanation was that *typicus,* like *superpictus,* was in some way unsuited for the development of the parasite. However, this supposition was quickly shown to be false when it was found in the laboratory that *typicus* could readily be infected by allowing it to bite suitable malaria patients and that the transmission of the infection to normal subjects took place without difficulty. It seemed unlikely that *typicus* did not bite human beings because it was found in enormous numbers in houses where human beings slept. Analyses of mosquito populations showed that *typicus* which never carried malaria, could be found in houses almost as readily as the good vector *elutus.* However, when a precipitin test was devised which readily identified the animal species from which a mosquito had obtained its last blood meal by the reaction of the blood found in its stomach, the curious fact emerged that *typicus* preferred to bite animals and then chose human habitations for a daytime resting place, whereas *elutus* not only slept with human beings but dined off them.

Further investigations were made to determine why this difference existed between these two varieties so similar morphologically that they could be distinguished from each other only with difficulty. It was considered that microclimate might be a factor; perhaps the temperature or humidity of the air immediately surrounding an animal might differ from that surrounding a human being and thus determine the mosquito food preference. In order to eliminate factors of temperature and humidity, the following experiment was devised: One end of a cylindrical screen wire cage was placed against the shaved side of a donkey and the other end against the abdomen of a man. Specimens of *A. maculipennis clutus* and *A. maculipennis typicus* were then admitted to the cage through a small opening in the center. Under these conditions all of the mosquitoes had an equal opportunity to

*Many entomologists now class *elutus* not as a variety of *maculipennis* but as an entirely independent species.

bite either man or animal. After they had fed, they were removed and the blood from their stomachs identified by means of the precipitin test. This experiment was repeated a number of times always with the same results, that it, the majority of *clutus* fed on man and the majority of *typicus* on the animal.

The experiment was modified in order to determine what led each species to its victim. A simple ether extract of human hair and one of donkey hair was prepared. When the ether had been evaporated off, it was found that the remaining volatile oils had a distinct species odor. The experiment was repeated except this time the volatile oil removed from human hair and which had a distinct "human" odor was smeared on the side of the donkey and the material derived from donkey hair was applied to the abdomen of the man. Under these conditions, the feeding preference of the two varieties of *A. maculipennis* was reversed, that is, *typicus,* which had always preferred animals, now showed a striking preference for man, and *clutus* now bit animals; therefore, some body emanation tended to guide these anophelies to their respective hosts.

Another factor important in malaria transmission is mosquito longevity. Inasmuch as it takes from 10 to 14 days for the infection to develop in the mosquito before transmission can occur, it is necessary that individual mosquitoes live at least this long. This factor is of prime importance in one locality in India, in which transmission is due to *Anopheles culcifacies.* These mosquitoes can be found breeding in large numbers throughout the entire year. Cases of malaria also occur throughout the year. Careful study, however, showed that transmission was taking place during only about two months. Cases of malaria occurring during the rest of the year were relapses. Study of the bionomics of *A. culicifacies* showed that in this particular locality high temperature and low humidity prevented adult mosquitoes from living long enough to develop the malaria infection during most of the year. The majority of mosquitoes hatching out could survive only long enough to mature and deposit their eggs. Recommendation to the local health department that their entire budget covering anti-mosquito measures be spent during the two months of the year when transmission was taking place served to increase effectiveness of their campaign.

The last important factor in determining whether or not a mosquito is an effective vector is density. In order to keep the infection alive, it is necessary that susceptible anophelines be present in and around human habitations in large numbers. A mosquito which fulfills this requirement most admirably is *Anopheles gambiae* of West Africa. This species, unlike most anophelines, does not require swamp water containing algae in which to breed, but may select any small puddle of water, as in foot tracks or any depression in the ground. In a country such as West Africa where it rains nearly every day for many months of the year, the problem of exterminating this mosquito by antilarvae measures is almost insurmountable.

The Human Host

In addition to differences in the nature and habits of species of mosquitoes which influence malaria epidemiology, additional complexities are furnished by variations in the human host. Were it not for the microscope, one would hardly recognize malaria occurring in the natives of West Africa as being the same disease which one finds in the population of Greek Macedonia. In some localities in West Africa surveys show that, although practically 100% of the adult population harbor *Plasmodium falciparum,* the parasite of the most malignant type of the disease, the adults suffer very little from their infections. For the most part they are free from fever, do not have anemia unless produced by other causes and their spleens, if palpable at all, are very small. It is surprising to examine hundreds of men and women, who are working every day and in apparent excellent health, and find that their blood is swarming with parasites. There is no doubt that they have built up a high degree of immunity to the manifestations of malaria by means of close association with the parasite for many generations. In Macedonia, however, the clinical picture is entirely different. The people residing there are, for the most part, refugees who came from non-malarious parts of Turkey after the last Greco-Turkish war. They have, therefore, little "racial" immunity. The Macedonians suffer intensely from malaria. Although the blood parasite index is lower than in West Africa, few Macedonians living in highly malarious regions have a red cell count higher than 3½ million and hemoglobin indices are not infrequently as low as 30 or 40%. The index of spleen enlargement approaches 100% and many spleens are so enormous that they almost fill the abdominal cavity. Bouts of fever are frequent and severe. These represent two extremes of human

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susceptibility to the manifestations of malaria. All graduations of susceptibility occur in different localites.

The Malarial Parasites

A third complicating factor in malaria is produced by variation in the virulence of different strains of parasites which occur within each species. This difference was strikingly illustrated in native West African adults, who suffered little, if at all, from the malaria common to their localities. When removed to other localities, perhaps only a hundred miles away, these natives came down with malaria of a severity approaching but never equaling that of non-immune Europeans. It has recently been found that, while almost all strains of malarial parasites are susceptible to the action of Atabrine and quinine, there are a few which respond more readily to one drug than to the other.

The foregoing epidemiologic factors are necessary for an adequate understanding of the transmission of malaria and are important in determining whether or not localized epidemics are likely to occur upon the introduction of the parasite from the outside.

Recent knowledge gleaned from studies of avian and monkey malaria have furnished the explanation for three phenomena which have puzzled malariologists for years. It has long been known that for 5 or 6 days after a malaria infection has been acquired by the bite of an infected mosquito, a patient is unable to transmit malaria either by having his blood injected directly into a susceptible subject or by means of mosquito transmission. During the 5 or 6 day interval after a monkey or canary has been infected by means of the bite of a mosquito, all of the infected animal's blood can be injected into another susceptible animal without this second animal acquiring the infection.

It has long been known that a certain proportion of patients will relapse after treatment, regardless of the drugs used and regardless of the dosage employed. Prolonged courses of treatment with either Atabrine or quinine do not seem materially to reduce the incidence of relapses.

It has also been recognized that antimalarial drugs do not act as true causal prophylactics but merely suppress symptoms. In other words, patients taking 0.3 Gm. of quinine daily or 0.1 Gm. of Atabrine daily, although protected during administration of the drug, may develop the symptoms of malaria upon cessation of treatment. In spite of this fact, however, suppressive treatment is well worth while, especially from the military point of view because by its means an army may be kept on its feet and fighting while in an endemic area.

Many years ago Schaudinn thought that he saw sporozoites, the form of the parasite injected by the mosquito, enter a red blood cell directly. We now know that this does not take place. There is a stage of development of the parasite, which takes place in the endothelial cells of the bone marrow, spleen and liver, which is intermediate between the sporozoite and the forms found in the red blood cells. This so-called exo-erythrocytic phase of development requires 5 or 6 days. Apparently a secondary exo-erythrocytic phase may take place at any time during the course of the disease. Inasmuch as Atabrine and quinine affect primarily only the erythrocytic forms of the parasite, that is, the trophozoites, and Plasmochin affects the gametocytes, especially of *Plasmodium falciparum,* and none of these drugs has any effect on either the sporozoites injected by the mosquito or the exo-erythrocytic forms, it is clear why these drugs act only as suppressives and not as true prophylactics. The infection may lie dormant in the exo-erythrocytic phase for months during quinine or Atabrine administration only to develop into trophozoites and produce clinical malaria when the drugs are discontinued. If exo-erythrocytic forms are present at the time of treatment, they are not killed by antimalarial drugs and a relapse may occur months or even years later. The presence of these exo-erythrocytic forms also explains why transmission of malaria does not occur during the first 5 or 6 days after mosquito inoculation. It is well, therefore, to keep these points in mind during the treatment of cases of malaria so that one will not expect antimalarials to accomplish the impossible. From 10 to 20% of malaria cases will relapse one or more times after treatment, regardless of the drug used and regardless of the amounts administered.

Recently Woodward and Doering have announced the complete synthesis of quinine. This latest triumph of synthetic chemistry opens the door to the possibility of the production of related compounds which may have new and unique antimalarial properties. However, it seems unlikely that a practical commercial synthesis can be developed in time for use in the present war.

Treatment of Malaria

Regarding the drug of choice for use in treating malaria, it may be said that Atabrine and quinine are qualitatively equal. Exactly the same results

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PLANNING FOR MEDICAL CARE*

JAMES R. MILLER, M.D.

The Author. *James Raglan Miller, M.D., of Hartford Conn. Chairman of the Council of the Connecticut State Medical Society.*

IT must be confessed that I feel somewhat as if I were bringing coals to Newcastle in addressing you on the general subject of prepaid medical care, for I know how actively you have been engaged in marshaling your resources to study this subject and I am reminded that you have done this with a background of more than a year's experience with Sickness Insurance by statute and also perhaps with the knowledge that because of many obvious conditions, your State is looked upon as a laboratory of social experimentation by many, even as far away as the banks of the Potomac.

I shall endeavor to show, first, that we must be satisfied to make progress step by step in our efforts to attain an ideal society, realizing that all along the way we must make many compromises in order that advances may be made in our field without dislocating affairs in others. Second, that there are some features of medical care which lend themselves easily to the so-called socializing process and others which do not and that we should facilitate this process in the one and discourage it in the other. Third, that tax supported medical and hospital care now given by the State and by municipalities is closely related to that care which is given to the economic class just above it, and should be improved in quality and should be given without stigma and, fourth, that self supporting wage earners should be given every encouragement to procure medical and hospital care by prepaid voluntary plans which make the utmost use of present facilities.

The problem of adequate distribution of our medical resources is one in common with the adequate distribution of food, shelter and clothing. Many honest social planners think that only revolutionary changes can possibly provide adequate medical care. Every legislature in the land has felt this pressure. It is greatest in times of depression but it behooves us now in times of relative prosperity to plan for the post-war period. We see this issue used already as a potent political force accepted by both major political parties, though the implications of many parts of the problem are not well understood.

Some of the high costs of medical care are inevitable and have to do with our increasing ability to keep alive many who formerly would have passed on to their reward with speed and economy. We must admit the enormous increase in cost which these advances have brought in their train. Apparently, physicians are somewhat held to blame for keeping Aunt Sally alive and running up the cost to many times that of a first-class funeral, but anyone who would make obvious suggestions at this point would quickly find himself in disrepute.

Coming to Rhode Island, I am reminded of the words of Samuel Johnson. "The reader will discover what always will be discovered by a diligent and impartial enquirer, that wherever human nature is to be found, there is a mixture of vice and virtue, a contest of passion and reason; that the Creator doth not appear partial in His distribution, but has balanced in most countries their particular inconveniences by particular favours." I am not acquainted with your "particular inconveniences" in Rhode Island—though I know that you must have them—for my experiences have been pleasurably bounded on the west by Watch Hill and on the east by the Squantum Club. I judge, however, that you have at least one compensating "particular favour" for I read in the April number of The Modern Hospital an article by your Governor, Mr. McGrath, in which he proposes State compulsory insurance through the medium of a voluntary plan which though you may know it by heart, I wish to restate:

"1. Utilization of existing facilities wherever possible, always avoiding the expense incident to the creation of new and duplicating features.

2. Compliance with the principles and practices of the profession or institution to be affected by a proffered program.

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*An address delivered before the 133rd Annual Meeting of the Rhode Island Medical Society at Providence, May 24, 1944.

3. Coverage in any program devised for as many people as can possibly be included.
4. Encouragement of the participation in a program which usually means industry and the worker to assume and share together financial responsibility for a program with a minimum State participation.
5. Avoidance of Federal or State domination and control of programs and utilization of the organization and facilities of the institution most affected by the program."

In closing he says, "States must meet their obligation or stop talking about States' rights. The same advice could perhaps be given appropriately to hospitals and the medical profession." I thoroughly approve of Governor McGrath's proposal and am reminded how shortly after I became engaged, I had the misfortune to have a letter, through misderection, fall into the hands of an acquaintance who returned it to me with the comment, "Young man, if you mean all you say, God bless you, my children."

Problems in Certifying Disability

The Rhode Island Cash Sickness Act provides cash benefits as insurance against loss of income through sickness and I understand that certification of disability has presented some of the difficulties which might have been anticipated. If the family physician is inclined to be too liberal, the fund is depleted whereas if the decisions are reviewed by employees of the Compensation Board with a view to maintaining the fund, both the patient and his physician are unhappy.

Under the old Federal Emergency Relief Administration, such reviews were accomplished with justice and with great satisfaction in many States by a medical board appointed not by the Government, but by the County Medical Association. The action of a physician was subject to review by a jury of his peers whose chief concern was giving medical justice to the patient and also to see that no fraud should besmirch the good name of Medicine. Given such a job to do, a Board of Review can be counted on to deal fairly with the situation. I expect that the fund might become depleted if rates have not been calculated at a level high enough to pay for adequate compensation, but I doubt that expenses would be increased as much as some fear and if they are, the rates should be increased to suit the needs.

So long as payments are made in cash, there is great elasticity and ease of administration; the patient may be able to make up the difference between benefits and costs and the quality of medical care is not greatly affected, but if medical services as such are guaranteed instead of cash payments, then we run the danger which all physicians fear, namely, that the professional services will be less and less well paid in order to conserve the funds and the inevitable result is that the quality of medical care will deteriorate.

It is difficult for the public to understand how genuinely concerned we are with the debasement of the quality of medical care though as individuals they understand it only too well, especially if they have suffered because of poor care. It is our duty through good public relations to make this phase of the subject absolutely clear.

It may interest you to know that a commercial insurance company with which we in Connecticut are negotiating, is willing to place in its contract a provision for just such a medical advisory committee, consisting of four, three to be appointed by the Society and one by the company. When you realize that this committee would settle disputed claims, you will see that at least one company thinks well of the integrity of any committee that our Society would appoint. I am sure that your Society also could be counted on to perform such a duty. Many disputes would settle themselves if the proper atmosphere of mutual trust is developed. The first move in the creation of this confidence is the willingness of the medical society to assume this policing function.

Basic Insurance Features Important

We must keep clearly in mind some of the fundamental features of insurance if we are to apply this method to the provision of medical care with success. The situation here differs from that in many countries which have compulsory health insurance. In those countries when sickness overtook the worker who lived constantly on the verge of destitution, there were no systems of organized charities both public and private as we have to relieve them. We have no such destitution in New England. Our wage levels are high and medical care can be had even though some of our public welfare practices may still be Elizabethan in their lack of human kindness. The phenomenal growth of non-profit and commercial plans for hospital, and more recently for medical care is clearing the scene and there is hope that the self-respecting wage earner will soon be able everywhere to provide against his major calamities.

We have two broad fields to cover, the wage earner who should be assisted to provide for himself and the indigent who must be helped by the

use of tax funds. These two fields overlap. Insurance after all is a device for fairly distributing among all those participating the actual losses or costs occurring to a minority from risks of a kind to which all are exposed. Unless Social Security plans are founded upon proper insurance principles, Social Security and insurance may be two entirely different things. If a person is unable to contribute to his own care, he should be given public or private help in an adequate amount and in a humane manner. It would appear conducive to the maintenance of self-respect, provided he is of sound mind, if he were given money or cash credit to buy his insurance through the regular channels just as he is given money to buy his groceries and to pay his rent. The Federal Government calls for this sort of a program when State public assistance authorities dispense Federal funds to the poor, but the same Government in the Children's Bureau has developed a coddling type of program in the care of the wives and children of service men.

Physicians generally, and organized medicine in particular, sense a struggle on this policy. If one wished to view the matter philosophically, one could say that Medicine objects to service contracts in the E.M.I.C. program but is developing them in its own prepaid medical plans in many States. Precisely at this point, we find an explanation for Medicine's attitude, for so long as service plans are under the control of the profession, adjustments can be made without the danger of deteriorating the quality of medical care. In service contracts physicians themselves underwrite the plan and it is probable that they would be willing to work under medical society control whereas they would not be willing, except as a patriotic duty in time of war, to participate in a Government controlled plan of this type.

Every prepaid medical plan must be set up with the knowledge that a great initial overload will be experienced in the first years. This is due to the inability of many to obtain a certain expensive surgical procedure which under the insurance plan they find available for the asking and the accumulations of some years are enough to wreck any plan which does not anticipate this load. For example, the Hollinger Consolidated Mines in Canada found that with the coming into force of its plan, tonsillectomies increased 400% (it took four years to clean out this accumulation.) The same is true in varying degrees for the operative treatment of chronic appendices, hemorrhoids, hernias, etc. Here then is a knotty problem which the inexperienced social planner ignores. In a given group of patients, should all the removable appendages be ablated and if so, who is to decide what are the medical needs, medical demands or perhaps only medical fads? Can the administrator of such a plan turn to the medical profession in confidence that his answer in Connecticut will resemble that given in Michigan. In this connection, I call your attention to an article entitled "Economics of Obstetrics" by J. D. Laux in the Journal of the American Medical Association—April 8, 1944. Mr. Laux reports the very considerable experience of the Michigan Plan and he observes that based on 3,500,000 member months' experience, the frequency of obstetric and gynecological operations is as follows: (1) Suspensions, (2) Hysterectomies, (3) Salpingectomies, (4) Dilitations and Curettages, (5) Deliveries (normal, Caesarean, ectopic and miscarriages, (6) Oophorectomies and (7) Ovariotomies. He adds that gynecological operations are required by 12% of all patients and represent 25% of total payments.

Now we know—at least we do in Connecticut—that the best thought in gynecology for the past 20 years has not recognized the need for such a high frequency of suspension operations, even if they include all procedures for prolapse. One might be cynical enough to paraphrase Churchill by saying "the magic of averages has come to the rescue of the gynecologist." No wonder the commercial companies are cautious about underwriting dependents, as I believe they informed your advisory committee.

Some of our extreme leftists think that all would be well if we could only adopt some medical care plans which seem to work so well in Russia. The other day I read the following in Paul Mallon's column: "The Surgeon General's office has announced that 25,000 to 30,000 men are being let out for physical disability each month and of these, 40% are classified as P-NS (psychoneurotics). A competent authority says that not a man has been discharged from the Russian Army for that reason." Whether or not these statements can be taken at their full face value, it seems clear that there is a difference in the attitudes of the authorities in Russia and in this country toward those who are not well adjusted to the demands of the Army and it would occur to me that some of these fundamental differences in the makeup of our peoples or in the attitude of the authorities in handling

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them might account for the success of a plan in Russia which would fail utterly in this country.

It might be marked in passing that there is an increasing feeling in this country that it is not a good thing for the moral fibre of the nation that everyone should be guaranteed freedom from the consequences of his own lack of industry and foresight.

Public Misunderstandings on Medical Insurance

For some, there is a sort of magic in the idea of prepaid medical insurance which leads them to believe that they are going to get more and better and cheaper medical care by the simple process of insurance against the need of such care. This may be true in the lower income brackets but the following story will illustrate how prosperous and presumably intelligent people are charmed by the Churchillian phrase of "the magic of averages coming to the rescue of the millions."

A friend of mine, a pediatrician of top rank, had cared for two boys from birth until they were ten and twelve years of age. Their mother came to him and said, "When Johnny was sick this Summer in Nova Scotia, we took him to a pediatrician. He was a very fine doctor and he had a most interesting method of practice which he used for his regular patients, charging I believe, $50 a head per year. When I realized all that we have paid you in the years you have cared for our boys. I wish that we had been able to take advantage of such a plan. I know that people who have little sickness might be less interested than we, but our boys have had expensive illnesses and we have never hesitated to call you whenever there was the slightest need nor have we questioned your prices."

My friend then said, "Let's take a look at the record", and it turned out that over the years from birth to the present time, it would have cost this family about 25% more than was actually paid. No one was more surprised than she but I would wager she still believes that somehow the "magic of averages" would have helped her.

In my opinion, the position of organized medicine in regard to prepaid medical care has never been better stated than in the joint document signed by our six New England States. I am prepared to carry that statement even further and say that we should not oppose furnishing at no cost facilities for any technical diagnostic procedure which has established its usefulness. We have accepted already the blood test for syphilis in this category and I believe likewise that any person should be able on request of his physician to have X-ray and laboratory examinations for the diagnosis of tuberculosis and other infectious diseases and for cancer, at public expense. I believe that we should interest ourselves in seeing that the physicians and other technicians who furnish such service are adequately paid and work under conditions which insure an ever improving quality of technical proficiency. Such a position, if taken by our profession, would dispell any imputation that we are less interested in rendering adequate medical care than in preserving economic advantages.

Therapeutic Procedures Not Considered

I have not included therapeutic procedures for two reasons. First, because that would be altogether too revolutionary a move whereas to include most diagnostic procedures would not require much change and, second, because I am not at all sure that therapy would thrive in a salaried, institutional setting. It is not enough to point to certain famous clinics whose reputations make it possible for them to secure the services of ambitious young men as apprentices almost without cost. Such systems in my opinion cannot be multiplied without limit to furnish medical service throughout the country, nor is there available the specialist personnel to man such a system. It may be that private enterprise in the field of therapeutics needs no artificial protection. I believe that it can be relied on to give better medical care than a salaried system would furnish. You may have noticed how definitely the British Medical Association has come out against a salaried medical service as being against public interest. Is it not possible then for us to come to a decision as to which branches of medical care can be institutionalized and which can not? Of one thing I am certain, that house and office calls as you and I understand them, cannot be subjected to severe regimentation. Our problem is, therefore, to determine the relationships which would most certainly assure good medical care in each particular field and for each economic category. One rigid system is not adequate.

With the development of prepaid medical care plans, especially if they are sponsored by state governments, it is inevitable that inferiorly trained physicians will clamor for courtesy privileges in hospitals which have previously denied them. Cries of discrimination are sure to arise and if the patient's safety is to be guaranteed and if at the same time unfair discrimination is to be avoided, hospital staffs must agree on rules and regulations, making use if possible, of accepted national standards and preferably with legal advice. Hospitals

must be prepared to shoulder their own responsibilities to the patient no matter what the political pressure may be and the State Medical Society may be forced to use its influence, taking care that it is exerted not in "restraint of trade" but clearly in the interest of the patient. Membership in a medical society should not be required but adequate training and integrity must be the test.

Connecticut's Approach to the Problem

You may be interested in some of the thoughts which have developed in Connecticut during the past six years in our study of prepaid medical service. Like most thrifty Yankees, our first thought is that we have profited greatly by experience which has been dearly bought by others. We are convinced that we should proceed step by step covering at first hospitalized illness of a surgical or obstetrical nature because its duration is known, because in the case of surgery it is usually undesired by the patient and because natural professional controls in force in all hospitals are exercised without any expense to the plan. As Governor McGrath suggests, "We should utilize existing facilities wherever possible." If these cases are insured, we cover not all but a large part of the expensive illnesses but what is more important, we shall at first deal only with insurable risks. While having babies is usually a desirable occurrence and is not properly a good insurance item, still there are natural limits to the rate of production, the case load can be calculated and there is a big sales value; in fact, it would be hard to sell a policy if wives were not covered during the lying-in period.

It seems obvious that there would be no great increase in the case load if we should cover obstetrics in the home and there is no reason why bona fide accidents including setting of fractures, opening of abscesses, etc., should not be covered both in the home and in the office for these claims are not subject to abuse and patients should not be compelled to go to a hospital to qualify for payment. Desirable as it may be to lift the load of expensive medical illnesses, this field cannot be undertaken safely by any infant organization as has been shown disastrously already. It may be possible later on.

Up to a year ago, we followed the conventional pattern of thought, namely, that we should develop a non-profit organization in which the physician should have a substantial voice and should develop a service contract with a fee table bogey, calculating payments on a unit system which would be paid on a par value or less, according to the amount of the physician's services and depending on the funds available each month for payment.

Wherever a service contract is carried, the physician must understand that he is the underwriter of the risk. If there is a greater demand than has been calculated, as in an epidemic, the unit payment for his services might be less than par. Because the rates have been calculated as appropriate for medical care of the middle economic group, physicians have been willing to underwrite such a plan only for people with a family income up to a certain limit, above which the insured would be paid not in service but in cash and the physician would charge his usual fee, even though it might be greater than the cash indemnity which the patient receives.

In a static society where wage levels are stable, where employment is reasonably uniform and where labor turnover is at a minimum, such a means test is not too difficult to apply but in our present situation there are many difficulties, just as there will be when work is slack, and the income level of the means test which would be fair at one time, would be inappropriate at another. It may be difficult at any time to tell how much the family income of a worker totals and borderline decisions will be largely guesswork. Certainly the clerical staff would be busy with this feature.

It is understandable, therefore, that in the Insurance State of Connecticut, we begin to wonder whether it would not be much simpler to manage this whole affair by cash payments and let the patient negotiate for his care in the open market. We believe that the market in Connecticut is relatively free and fair-priced. Administrative difficulties will be fewer under a cash indemnity system and they might even disappear almost to a vanishing point if we could persuade insurance companies to expand the scope of their activities which already cover 10% of all Connecticut people. We noted also that one-third of our people were already covered by prepaid hospital insurance contracts.

The House of Delegates of the Connecticut State Medical Society last December authorized the development of a commercial carrier plan and this would by now be well under way were it not that we have all been so busy and especially because of the serious illness of a key individual in the insurance company. We hope, however, to see these contracts offered to the public before long and it is significant that one other company has approached us for approval of its contracts.

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CARBON TETRACHLORIDE POLYNEURITIS

A Case Report

CHARLES L. FARRELL, M.D. AND LAURENCE A. SENSEMAN, M.D.

The Authors: *Charles L. Farrell, M.D., of Pawtucket R. I., and Laurence A. Senseman, M.D., of Saylesville, R. I.*

RECENT INTEREST in the industrial hazard of carbon tetrachloride poisoning has been stimulated by numerous articles appearing in leading industrial publications.

A rather unusual effect of this chemical on the nervous system is here reported in a case study.

H. C., age 38, an enlisted man at an air base in Texas first noted weakness of his legs on April 19, 1943 at which time he noticed pain in the calves of his legs and had difficulty in walking from his work to the barracks. He also noticed numbness in his fingers and hands about this time. The following day he was unable to carry a bombsight, weighing about 25 lbs., which he had been in the habit of doing. The pain disappeared the second day but the weakness persisted, especially in the ankles, knees, thighs, and wrists. These symptoms the patient attributed to the change in temperature as he was working in an air conditioned department. His work consisted of cleaning the Nordin bombsight. This is accomplished by a fine spray of carbon tetrachloride which saturates a cloth wrapped around the fingers. He is thus exposed to this substance about eight hours a day.

This condition H. C. did not report to his commanding officer as he was soon to have a furlough and was planning to be married in Rhode Island. On his way home he had great difficulty in walking and was unable to carry his own bags, and could only go upstairs where there was a railing. He was able, however, to go through the marriage ceremony with some difficulty and assistance.

There was no evidence of alcoholism, his appetite was good and he apparently had been eating a well-balanced diet but had lost about 8 pounds since onset of the illness. Previously, he had had no serious illnesses.

Physical and routine laboratory examinations were essentially negative except for the neuro-muscular system. There was a marked weakness of the wrist and ankle joints on extension and flexion. The patient was unable to rise from a squatting position without assistance, and was unable to raise himself on the balls of his feet. Deep reflexes were greatly diminished and the ankle jerks were not obtained, Babinski and Hoffman were negative. No loss of sensation for pin prick, vibratory, and position sense. There was noted an unsteadiness in his gait and he walked as if his legs were very heavy. The grip in both hands was very weak. There was no tenderness with deep pressure over the peripheral nerve trunks.

The patient was given 100 mgs. of Vitamin B complex, subcutaneously and Thiamin Chloride by mouth 10 mgs. t.i.d. This was repeated on the five days remaining in his furlough.

He returned to the air base where he was hospitalized and treatment continued from May 20 to July 6. He improved rapidly and was discharged from the Army on July 26.

The last visit was made on August 19, 1943, and the patient presented no evidence of his former illness. Reflexes were entirely normal and there was no evidence of weakness of his extremities.

Conclusions:

We are reporting this as a case of polyneuritis due to carbon tetrachloride poisoning by absorption through the skin of the hands. The response to Vitamin B therapy plus the discontinuation of this work, resulted in complete recovery.

Carbon tetrachloride is used to a considerable extent as a non-combustible solvent, cleaning agent, fire extinguishing agent and degreasing agent in industry.

Effect: There is a local irritating effect. It is also somewhat narcotic, producing muscular spasms and cramps, with slow recovery.

Absorption: Carbon tetrachloride is easily absorbed by the mucous membrane, the lungs and by the skin.

Acute Poisoning: Acute poisonings have occurred by medicinal use. This produces symptoms of nausea, vomiting, abdominal distress, diarrhea,

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AUGUSTINE W. EDDY, M.D., Woonsocket	WILLIAM P. BUFFUM, M.D., Providence

RETAINING THE VOLUNTARY STATUS

Writing in The Commonweal recently, Hilde Fitzgerald, a member of a group in London devoted to research in economics, attempts an analysis of the proposed National Health Service for Britain. In the discussion of the status of the voluntary hospitals the observation is advanced that they are free either to stay outside or to join the services, and if they follow the latter choice they will have to conform to certain general conditions but will be allowed to remain autonomous units. According to Fitzgerald "they are encouraged to retain their voluntary status which can only be done by emotional appeals to public charity which are out of place and bound to be less and less effective in an age when public service has replaced individual benefaction."

Such may be the thinking in England. We hope that it may never be here. We admit the expansion of public services in this country, but we recognize these expansions as going hand in hand with our American methods of individual philanthropy and voluntary effort to further community enterprises that are to benefit all individuals. The day that we allow government and state service to usurp completely private initiative, even in the field of benevolence, will mark a decline in the American way of thought and action which has characterized our national progress.

At a time when state dependency flourishes abroad, and when even in our own State we are faced with proposals for compulsory methods to secure hospital benefits for the employed worker, our faith in the American way is sorely tested. It is with pride therefore that we note within the past month three significant indications of the continued strength of the voluntary method in the matter of greater hospitalization for the people of Rhode Island.

Foremost stands the announcement of the Blue Cross that it has enrolled its 200,000th member of a state population which in normal times totalled approximately 715,000. This achievement is evidence of the desire of the people of this area to provide for their own needs in their own way. The additional announcements of new types of membership which will provide for the acceptance of direct applications from persons who are unemployed, retired, or self-employed, and of an employer-participation contract allowing more liberal benefits where a high percentage of the employees of an organization are enrolled, now pave the way for the enrollment of thousands previously denied the opportunity through organization technicalities.

Equally encouraging has been the ready response for funds to build a new Miriam Hospital. At a time when many demands are being made upon the

individual, and in the midst of the campaign for the largest war bond goal in history, the hospital drive has been launched with reports on the initial returns indicating that the high goal sought will be realized.

Finally, we point with interest to the outstanding personal contribution of the Peck estate in Barrington to the Homeopathic Hospital to be utilized as that institution deems advisable. This generous gift of land and property paves the way for the establishing of a hospital in a county of more than 25,000 residents where no hospital presently is in operation.

Individual benefaction and the heritage of personal initiative do not merely survive in Rhode Island. They flourish here.

WOUNDS AND DISEASE

America's amazing war production has stolen the show from an even more remarkable achievement, and that is the achievement of our medical staffs. Military men call what the doctors and sanitary engineers have done "little short of a miracle." The figures certainly support them.

Disease has always killed more soldiers than bullets and bayonets have. In the Mexican War of 1846-7 the ratio was six men lost from disease to one lost from wounds. In the French Army of the Crimean War it was 10 to one. Among the Germans in the war of 1870-1 the ratio was 12 to one. It was even higher among our troops in the Spanish-American War.

In the light of these figures it is no wonder that Army and Navy men describe the achievements in the present war as miraculous.

Death from disease in both Army and Navy is now a minor factor. Typhoid and typhus, those twin scourges, have been practically eliminated. Venereal disease is incomparably lower than it has ever been in any army at any time. Not one case of tetanus has developed in an American soldier who has been properly immunized.

These almost incredible statistics hold through all other diseases. Meningitis, pneumonia, tuberculosis, each of which showed high death rates even as late as the First World War, have dropped to low percentages—pneumonia to less than one per cent.

The figures concerning wounds are equally impressive. Ninety-seven men of every 100 who are wounded are saved. No war has even come near such a record. This great story of the successful conquest to save men's lives in the midst of war is, beyond all doubt, one of the most heartening chapters in human history.

Editorial, *Providence Journal-Bulletin*, June 18, 1944

OUR NEIGHBOR, ROGER I. LEE

Dr. Roger I. Lee, whose name leaves the uninformed in doubt as to whether he belongs to a First Family of Virginia or a State Street banking company, has been chosen President-Elect of the American Medical Association. But we hasten to repudiate Virginia's claims. He is as New Englandish and Bostonese as salt codfish and baked beans. Born on the North Shore, educated at Harvard, on the staff of the Massachusetts General Hospital, married to a woman with a famous local name, he is essentially a New-Englander.

Four years ago the Medical News of the Providence Medical Association pointed out that until then only one New England doctor had been President-Elect of the American Medical Association. This was apropos of Dr. Frank Lahey's accession to the office. It is unnecessary to tell anyone interested in American Medicine how well Dr. Lahey carried out his assignment. More recently Dr. James Paullin of Atlanta, Georgia, was appointed. He got off on the right foot by an interneship at the Rhode Island Hospital.

In these parlous times we are glad that medicine is drawing heavily on this section for the best of its strength and virtue. But there is nothing narrow or poorly provincial about Dr. Lee's career. A reading of his record as presented on the editorial page of the Journal of the American Medical Association is proof of this.

From the time when he was one of the first Americans to reach France in the last war his activities have spread far and wide. He has held so many positions in the American Medical Association that Chicago must be nearly as familiar to him as Boston and Cambridge. He has membership in the Royal College of Physicians and has been President of the American College of Physicians, and he belongs to many other learned societies.

Not only does he contribute services which truly entitle him to all these honors, but in his work he wins people by his grace and charm. As befits a Harvard man he is dignified and restrained but exceedingly effective. Presiding as President of the Massachusetts Medical Society this year he introduced one by one all those whose importance entitled them to be seated at the long head table.



ROGER I. LEE, M.D.
of Boston
President-Elect of the
AMERICAN MEDICAL ASSOCIATION

What a chance to bore the throng before him. The few gracious but apt words that made us acquainted with each personality delighted his audience.

One great responsibility that he has shouldered and of which we have heard little said is his membership on the Board of Fellows of Harvard University. The government of American colleges and universities has been almost exclusively in the hands of lawyers and business men. Physicians have been conspicuous by their absence. The last one that Brown had was Dr. W. W. Keen, appointed not long after the Civil War. There is an honest difference of opinion as to the proportion of the country's wisdom carried in the calvariums of these two groups.

The outstanding position of Harvard in the educational field of America throughout its history is a tribute to the wisdom of its management. Roger Lee, the physician, one of the five fellows of Harvard, is undoubtedly a powerful figure in American education.

So we in New England are pleased and proud that once again a neighbor has been chosen to head this great body of physicians and we know that our whole country will profit through his great talents and earnest services.

DEMOCRACY AT WORK

We were reaching for the telephone number of our favorite ophthalmologist when we re-read the news item and realized that our vision had not betrayed us.

It was true. Two hundred persons were being sued for not paying their hospital bills when they were considered perfectly able financially to meet the charges.

It's plain they haven't social security in Cambridge. How can people there feel secure about a social afternoon playing the horses at Suffolk Downs, when hurrying home to a late dinner they may break a leg, be rushed to the Cambridge Hospital and months later have the City Solicitor spring a trick like this on them?

In this age when the public has been weaned from the old New England principle of cash on the line for services rendered, it was a shock—but a vitalizing one—to find a city solicitor with the backing of his city government opening suit for the recovery of some $10,000 from 200 residents who had failed to pay their hospitalization charges at the Cambridge City Hospital.

Free hospitalization for persons unable to pay, but not for the citizen who is capable of meeting the charges, claims the city solicitor.

The suit is on. The pattern may well be copied.

BLUE CROSS EXPANSION

A new type of membership providing for a direct enrollment whereby persons unemployed, retired, or self-employed may make direct application to Blue Cross for membership was recently approved by the board of directors of the Hospital Service Corporation. If the plan meets the approval of the State Department of Insurance it will make the hospitalization plan available to thousands of Rhode Islanders who desire the protection.

Also announced by the board of directors was a plan for an employer participation contract under which more liberal benefits will be provided where a high percentage of the employees of an organization are enrolled in the Blue Cross program.

If all the arrangements proposed can be effected to the satisfaction of the state insurance department the plans will be offered to the public late in August.



A Radio Program of Interest to All Physicians . . .

"THE DOCTOR FIGHTS"

starring RAYMOND MASSEY

HERE is a Report to the Nation on the wide-spread activities of America's doctors in a world at war, not only on the battlefronts, but on the home front as well. Documentary histories of medical heroism, carefully authenticated and ethically presented, should prove of interest to every physician, military or civilian. The comments or suggestions of the profession are welcomed.

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ARTHUR H. RUGGLES, M.D., *Editor*

CHAPIN HOSPITAL ADMISSIONS

(The purpose of the insertion of this notice in the RHODE ISLAND MEDICAL JOURNAL *is to apprise the members of the medical profession that the Charles V. Chapin Hospital will admit patients from anywhere within the State on equal terms with those of Providence.)*

In order to conform with the law enacted at the recent session of the Legislature in connection with admission of out-of-town patients to the Charles V. Chapin Hospital, the administration wishes to bring to the attention of physicians, hospital superintendents, public health officers, and various Departments of Public Welfare of the State, rules and regulations which have been formulated to meet the new situation, effective July 1, 1944. It will be the serious intention of the hospital to conform with this recent enactment in its entirety. Many problems, that will require patience, will have to be ironed out. Your cooperation will be solicited and most gratefully received.

Patients will be admitted only on the recommendation of a physician or hospital. Psychopathic patients will be admitted only if a Temporary Care Paper signed by a physician or police officer accompanies them. This is required by law. The forms may be secured at this hospital, police departments, and various hospitals throughout the State.

It is to be remembered this is not a general hospital. The Chapin specializes only in communicable diseases and psychopathic patients who require temporary care. A safe census will limit the number of admissions. The administration will be the sole judge of this decision. Physicians will be expected to give what information is available to them concerning the patient's diagnosis and his financial status.

It will devolve on the patient or the sponsor to provide transportation to the hospital from outside the city limits as the City of Providence provides ambulance service only within the confines of the City.

The charge per day for ward care is $4.00; for semi-private care $5.00; and for private care $6.00. Service charges must be paid one week in advance.

Visiting privileges are definitely restricted and those interested should contact the hospital by telephone to determine the correct days and hours before planning to visit a patient as no special privileges can be granted those who may come from distant parts of the State and who may be in ignorance of the hospital rules.

CENTENNIAL OBSERVANCE ON OCTOBER 4

The Trustees of Butler Hospital are planning a second celebration of the institution's Centennial on October 4th, 1944. This observance will be of a lay nature and open to the public. It is planned to hold "Open House" all day at the Hospital, giving an opportunity to the general public to inspect the wards, the shops and all the various facilities of the oldest hospital in Rhode Island.

On that evening a public meeting is planned in the auditorium of the R. I. School of Design, where the Governor, the Mayor, the Director of the State Department of Social Welfare, and the President of the R. I. Medical Society will bring Centennial greetings. Dr. Arthur H. Ruggles, Superintendent, will speak on the institution's work and the main address will be given by an outstanding leader in the medical world. Presiding at the meeting will be Mr. John Nicholas Brown, Trustee and Chairman of the Centennial Committee, and great-grandson of the original benefactor of the Hospital.

SPENCER NAMED SECRETARY

Paul J. Spencer of Butler Hospital has been appointed Secretary of the New England Hospital Assembly by Oliver G. Pratt, President of the Assembly and Director of the Salem Hospital, Salem, Mass. Mr. Spencer, whose duties commence immediately, succeeds Gerhard Hartman of Newton Hospital, whose resignation has just been accepted.

Help Yourself to Future Success

The *Doctor's Success* depends largely upon the number of Future Patients — who will *come to* and *return to* his Office.

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PROVIDENCE

SOCIO-ECONOMIC PROBLEMS OF DENTISTRY

Excerpts from a report made by the American College of Dentists by Dr. George W. Wilson, Chairman, Committee on Socio-Economics

What is the present status of dentistry?

It is transitional. Dentistry is still regarded as a profession in which individualized personal relationship exists between patient and dentist. It is, however, being socialized and brought under government control and supervision as evidenced by the growth of dental clinics for examination, advice and correction, public school clinics, clinics in industry, etc., paid for and controlled by government agencies.

The present status of dentistry is one of tolerance and partial acceptance in the family of social organizations. The progress of dentistry in the past hundred years, and especially the last twenty-five years has been remarkable. But progress toward a better place in the social fabric is hampered by dentistry's apathetic attitude toward her opportunity and her perpetual failure to recognize and discharge her obligations in that field. The widespread publicity given to the importance of dental attention by our military services may force dentistry to develop a plan to provide for a greater demand in the post-war era. The status of dentistry may rise or fall as it succeeds or fails to cope intelligently with the social problems of the near future.

The advances in medical knowledge made by dentists and the greater care exercised in relation to the general health of their patients have raised dentistry in the regard of the medical profession. However, there still remains much to be done before the status of dentistry in this field may be considered to be satisfactory.

What are the trends today in the status of dentistry?

While the present status of dentistry may be assayed as fairly satisfactory, there are signs that dentistry stands at a cross-roads, leading either to further progress and greater advancement, or backward to a lower place in the scale. The direction in which dentistry will go depends definitely upon the intelligence, vision, sincerity, energy and indefatigable efforts of the leaders developed in the several fields of organization, education, and literature.

Is the supply of dentists sufficient to provide for dental needs? How can the supply be best utilized?

The present supply of dentists is controlled largely by the demand for dental service under a system of private practice. Accepting the figures of the committee on the cost of medical care that dental man power provides 20% of the population with adequate service and the other 80% with emergency service only, the answer to the question "Is the supply of dentists sufficient to provide for dental needs" is no.

It is estimated that if all initial dental needs were taken care of it would require at least 115,000 dentists to supply adequate maintenance care.

The present supply can best be utilized by increasing the efficiency of dentists through more general use of hygienists, technicians, and assistants, better planned offices with multiple operating rooms, modern equipment.

How can dental service be made available to all under present methods of distribution?

It is impossible to make dental service available to all under present methods of distribution. With the nation's normal complement of dentists serving apeace-time civilian population, less than 25% of that population secured dental care. War-time conditions have reduced the number of available dentists and consequently have kept the individual practitioner who is caring for a civilian practice busier than ever in caring for a smaller portion of the population. Economics, education, available time combine to eliminate the possibility of the present system producing dental care for all.

The possibility of the organization of the profession to render such service to all, particularly the low income group, has been under discussion for many years. Such organization, without outside aid, is doubtful, if not impossible.

How can dental service be made available with outside assistance?

This subject is the most complex one confronting organized dentistry, government and welfare agencies. It is their mutual problem. So far no practical program has been formulated by any of these three groups. Children's dentistry programs have been offered as the logical starting point. Various health insurance programs have been studied and been discarded one by one. A cooperative effort on a voluntary basis with participation by employer and employee has been attempted without success.

Private philanthropy in the past has been invited to support various dental projects by the profession's leaders. With several notable exceptions, such support has not been made available. It has been provided for the study and elimination of more dramatic diseases than caries and diseases of the mouth. Speakers at dental meetings in New York City, during the past ten years, have presented

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A.M.A. ENDORSES WELLS CELEBRATION

At the 94th Annual Meeting of the American Medical Association held in Chicago during the past month the House of Delegates adopted the following resolution which was introduced by Dr. James R. Miller of Hartford, Connecticut.

"WHEREAS, 1944 marks the centenary of the application of a practical method of anesthesia by nitrous oxide by Dr. Horace Wells of Hartford, Connecticut; therefore be it

"RESOLVED, that the House of Delegates of the American Medical Association commends and endorses the celebration during 1944 of the centenary of this application of nitrous oxide anesthesia by Dr. Horace Wells of Hartford, Connecticut."



The discovery of penicillin and of its wonderful power to successfully combat death-dealing germs has brought medicine to new heights of ability to cope with many hitherto baffling ills that beset the human body.

The intriguing story of how officials of pharmaceutical concerns gave penicillin production the "green light" and, with the invaluable aid of governmental agencies, feverishly planned for an adequate production—how mycologists, bacteriologists, chemists, and chemotherapists worked day and night—how 22 companies poured $25,000,000 to $30,000,000 into this enterprise—comprises a never-to-be-forgotten episode in the saga of American pharmaceutical industry.

We are proud that Roche has kept in full step with the great march of scientific and engineering progress which ere long will place the wonder drug—penicillin—in the hands of every physician . . . HOFFMANN-LA ROCHE, INC., ROCHE PARK, NUTLEY 10, N. J.

PENICILLIN 'ROCHE'

AMERICAN MEDICAL ASSOCIATION MEETING

June 12-16, 1944, at Chicago

Report of Alex M. Burgess, M.D., Rhode Island Delegate to the House of Delegates of the American Medical Association

YOUR DELEGATE was in attendance at the above session throughout its entire course and submits the following report.

General Considerations

The session was planned and carried out in the usual pattern of sessions of the Association in recent years and conformed to the customary high standard and tradition of such meetings. The total registration was 7,187 for the first four days. Considering the present day conditions of war time transportation and the extra burdens of civilian practice this attendance must be considered remarkable. It certainly affords ample evidence of the enduring urge of members of our profession to keep up with the progress of the science and art of medicine.

The Scientific Assembly

Judged by those sessions of the Scientific Assembly which your delegate was able to attend, the meetings on the whole were very satisfactory and the calibre of the work reported was high. As was to be expected the influence of the war was strongly evident and many valuable contributions were made by fellows now serving with the armed forces. In a number of such instances the data presented could not have been obtained except under war conditions which presented the opportunity to study large homogenous groups of individuals under controlled conditions. The scientific exhibit, as is usual, furnished ample opportunity for study and intimate discussion of many striking advances in medicine, surgery and the specialties. Of the Rhode Island physicians who attended the session, one, Dr. Francesco Ronchese presented a paper in the section on Dermatology. A further discussion of the Scientific Session is not appropriate to this report.

The House of Delegates

The surprisingly large volume of business which was carried on and finally disposed of in the sessions of this body on June 12th, 13th and 15th will of course be reported in detail in forthcoming issues of the *Journal* of the American Medical Association. It is the purpose of this report to bring to your attention certain of the "high spots" of the work.

1. *Board of Trustees*

The voluminous report of the Board of Trustees, covering as it does a very wide range of subjects and occupying 127 pages of the Handbook for Delegates was adopted in its entirety. Some of the matter in this report was further studied and amplified in the reports of various reference committees. It includes separate reports of various Councils and Bureaus of the Association and to anyone who fails to realize what organized medicine is doing for the public and the profession in its day by day work perusal of this document will be instructive.

2. *The Council of Medical Service and Public Relations*

It was the privilege of your delegate in company with your Executive Secretary to represent Rhode Island at a meeting of this Council held on June 11th, the day before the opening of the Session. This meeting was primarily for the purpose of discussing the opening of a Washington office, which actually had already been accomplished by the Board of Trustees under authority granted them by the House of Delegates of the 1943 Session. Dr. Joseph Lawrence, who has for twenty years been carrying on an office of Medical Information at Albany, had been put in charge on a part time basis. It was explained that this office was not to be a "lobby" in the accepted sense of the term, to which both the members of Congress and the profession appear to be strongly opposed. The purposes of the office are as follows. (1) To furnish information to members of Congress as to the attitude and opinion of the medical profession regarding issues under consideration. (2) To furnish information to various agencies having to do with health problems (for example the Public Health Service, the Children's Bureau of the Department of Labor and others). (3) To furnish information to the medical profession as to what legislation related to medical and health problems is under consideration in Congress.

In carrying out this last function it was pointed out that there will be need of a key man or committee in every state and local society to act in the prompt "fanning out" of information as to pending legislation as well as the gathering in of medical opinion. It is intended that such men keep in contact with their local Senators and Representatives in order to keep them informed as to the reaction of the local profession to contemplated Congressional action.

The state of New York has, as mentioned above, for twenty years maintained an office of this character at Albany under the direction of Dr. Lawrence. The work of this office is said to have been highly effective and free from criticism or reproach of any sort. A similar system has been operative in Wisconsin, Nebraska and several other states. Before the end of the Session it was announced that the services of Dr. Lawrence had been obtained on a full time basis for the work in the Washington office. In the opinion of your delegate this plan is deserving of your support.

continued on next page

RHODE ISLANDERS AT A.M.A. SESSIONS

According to the daily bulletins issued by the American Medical Association at the 94th Annual Session the following Rhode Islanders were in attendance at the meetings: Dr. Charles J. Ashworth, Dr. Philip Batchelder, Dr. Alex M. Burgess, Dr. B. Earl Clarke, Dr. Jesse P. Eddy, 3rd, Mr. John E. Farrell, Dr. Frank T. Fulton, Dr. Edmund T. Hackman, Dr. Arthur W. King, Dr. Gordon J. McCurdy, Dr. Francesco Ronchese, Dr. Vincent J. Ryan, Dr. Meyer Saklad, Dr. Edmund A. Sayer, Dr. Laurence A. Senseman, Dr. Edward J. West, and Dr. George F. White.

The report of the Council on Medical Service and Public Relations includes several other important items among which are, (1) A reiteration of approval of prepayment hospital plans and prepayment plans for meeting the costs of medical care on a cash indemnity basis and (2) a reaffirmation of the value of having a single federal health agency to include all governmental functions concerned with health.

3. *Reference Committees*

The following parts of the reports of the twelve reference committees, as adopted or rejected by the house, are deemed of sufficient interest to be called to your attention. In addition to the matters here reviewed the committees dealt with a large volume of work of a more or less routine nature. Of the resolutions introduced by delegations from the various states (in many of which the final evolution of the main idea occurred only after a seemingly interminable series of whereases) some were of a quite controversial nature but were, in the judgment of your delegate, dealt with in a satisfactory manner. Among these were resolutions favoring (1) reapportionment of the number of delegates from each state so that every state should have a minimum of two, (2) the support by the American Medical Association of the United Health League (a league formed by the medical societies of certain of the western states with an office in Washington), (3) retirement of the Secretary and General Manager with the title of Secretary Emeritus and (4) replacement of the Editor of the Journal. None of these was approved by the House of Delegates. Most of these controversial matters were discussed at the Executive Session held on the afternoon of June 13th which was not open to the press.

Another matter which was brought out at the first session was the matter of the non-deferment from active duty of men who wish to study medicine. The decision of the Selective Service authorities to allow no more men suitable for induction to go to medical school means, it was pointed out, that from this summer on, the students of medicine will have to be recruited largely among women and men classified as 4F. This matter was discussed at some length by Dr. Frank H. Lahey of the Procurement and Assignment Board, who stated that this step is a dangerous one which will be a definite threat to public health in 1948 and 1949 and may well endanger the very existence of a number of medical schools. Dr. Lahey reported that he had interviewed the Secretaries of the Army and Navy, Mr. Byrnes and the President but had found that the position of General Hershey (which is that in spite of the serious consequences of this move the needs of the armed forces come first) is to be upheld. A resolution requesting that this situation be corrected was passed by the house. The possibility of the return to the Medical Schools, as students, of 2000 men who had served two years in either army or navy has been suggested and would help somewhat to overcome the shortage. Admiral Ross T. McIntyre addressed the meeting and voiced a point of view in agreement with that expressed by Dr. Lahey.

Among other matters covered in reports adopted by the house were the following: The report on "Emergency Maternal and Infant Care" of the families of service men was in entire agreement with that adopted by the committee of our own Rhode Island House of Delegates. Approval of the objectives was expressed but disapproval of the method of making payment. It was further advised that the administration of this work be assigned to the Public Health Departments of the various states. Disapproval of a bill to appropriate ten million dollars for use of the U. S. Public Health Service in anti-tuberculosis work was recorded. In expressing this disapproval the need of anti-tuberculosis work was admitted but objection was voiced to centralization of this work under the federal Public Health authorities and the belief was expressed that the work should be done by the states.

At the final session of the House of Delegates Dr. Roger I. Lee of Boston was elected to the office of President Elect, thus marking the second time within five years that a New England physician has been so honored. The complete slate of officers elected by the House of Delegates to serve for 1944-1945 is as follows: President, Herman L. Kretschmer, Chicago; President-Elect, Roger I. Lee, Boston; Vice President, Stanley J. Seeger, Texarkana, Texas; Secretary, Olin West, Chicago; Treasurer, J. J. Moore, Chicago; Speaker of House of Delegates, H. H. Shoulders, Nashville; Vice Speaker, R. W. Fouts, Omaha; Board of Trustees, Louis H. Bauer, Hempstead, N. Y.; E. L. Henderson, Louisville; Judicial Council, Edward R. Cunniffe, New York; Council on Medical Education and Hospitals, Charles Gordon Heyd, New York; Council on Scientific Assembly, Charles H. Phifer, Chicago; Council on Medical Service and Public Relations, A. W. Adson, Rochester, Minnesota, W. S. Leathers, Nashville, Tennessee, for a one year term; E. J. McCormick, Toledo, Ohio, Thomas A. McGoldrick, Brooklyn for a two year term; John H. Fitzgibbon, Portland, Oregon, James R. McVay, Kansas City, Missouri for a three year term.

With the meeting place for the 1945 session already established as New York, and the 1946 session for San Francisco, the House of Delegates voted to meet in 1947 in Atlantic City.

While a number of other matters were decided by the House of Delegates, those mentioned above are, in the opinion of your delegate, the most worthy of being included in this report.

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PLANNING FOR MEDICAL CARE

continued from page 333

During the Spring, renewed interest in the original non-profit contract plan began to appear chiefly among the sponsors of the Connecticut Plan for Hospital Care. They feel the need of satisfying a demand for this coverage. To what extent there is actual competition between the commercial carrier and the non-profit plan, I am unable to say. Certainly, all the elements of a competitive situation are present and it is to our interest to see that proper advantage is taken on behalf of the public.

Shortcomings of Insurance Plans

I have long entertained a pet idea that the whole development of prepaid hospital insurance in this country has been somewhat queer. It seems to have been devised by salesmen and not by good insurance thinkers though I do not under-estimate "sales appeal" as a necessary part of insurance. I mean that the standard prepaid hospital insurance begins to pay from the first day and will reimburse for relatively small hospital expenses which certainly cannot be a great financial strain to anyone. On the other hand, it offers little or no protection to the poor chap who has to pay for prolonged hospital care. These plans lack to a considerable extent one of the prime requisites of sound insurance, that is, the coinsurance feature; the insured should have to dig into his own pocket a little. From a social standpoint, the real catastrophies should be provided for. It is as if we insured against the loss of toes but not of legs. I believe that it is possible to calculate insurance premiums which will cover the costly episodes of illness if every patient who enters the hospital has to pay for a part of his first week's expense.

Medical and hospital care given by States vary widely in different parts of the country and within a single state may differ according to the type of patient treated. It has always been easier to obtain funds from the legislature for the treatment of the tuberculous than for the insane. Perhaps it is because of the menace of infection from tuberculosis but I have wondered whether it might not be due also to the fact that the mentally ill are no longer voters and their complaints do not register seriously with the authorities.

Our Societies might well interest themselves more than they have done in securing a high grade of medical care for all our municipal and State wards and in removing the stigma of pauperism from those who must accept public assistance through no fault of their own. There is a borderland between medical and hospital care which is given by tax funds and that which is given by insurance funds and there must be worked out a proper humane formula to integrate these two methods of assistance so that the sick may receive good care no matter who pays for it.

Responsibility of Medical Profession

I have tried to portray some of the difficulties in the development of prepaid medical care, indicating that a step by step program should be planned. I have viewed with great satisfaction the proposals of your Governor. I have suggested some changes in the pattern of medical practice which you will find less radical five years from now than they appear today and I have touched on the need of bettering our tax supported medical program.

Physicians have been slow in interesting themselves in these matters and are only too willing to let a few hard-working committeemen do all the planning though they reserve for themselves the right to criticise. They must become interested. De Toqueville said, "It is democracy's leading task to persuade men to busy themselves with their own affairs", and as our Secretary, Dr. Creighton Barker once said, "The medical profession has a definite responsibility toward Society as a whole that cannot be completely discharged by the individual physician. We are not just odd little men here and there with a private enterprise of doctoring; we must be concerned with the affairs that are larger than ourselves.

CARBON TETRACHLORIDE POLYNEURITIS

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unconsciousness, coma, hemorrhage of mucous membranes, hemorrhage of the lung, kidney damage, suppression of urine, liver damage with jaundice and early death.

Sub Acute Poisoning: Delayed fatal poisonings have occurred within one or two weeks after a single inhalation of high concentration.

Industrial poisonings are reported but are comparatively rare and the illnesses caused by inhalation in industry are usually mild. The dangers of carbon tetrachloride when used as a solvent are not very great as a rule. It must be remembered that high concentrations are considerably dangerous. Long continued contact allows poisoning to occur through the external skin.

Industrial control rests upon the careful selection of workers and only those who are in good health and physique should be employed. No underweight, undernourished, obese or diabetic workmen should be used and no person with a history of liver damage or blood diseases.

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Aids in Relieving Blocked Sinuses

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HEMO-VITONIN is especially designed as a prophylactic, intended to prevent anemia in conditions where it is prone to occur; pregnancy, lactation, anorexia, acute and chronic infectious disease, convalescence, gastro-intestinal disorders (diarrheas, chronic gastritis, peptic ulcer, etc.), special diets.

Each fluid ounce of Hemo-Vitonin contains:

Alcohol, 14%
Liver Concentrate equivalent to 50 grams Fresh Liver
Vitamin B_1 (Thiamin Chloride), 218 Int'L Units
Vitamin B_2 (Riboflavin), 340 Gamma
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Pantothenic Acid, 1.2 Milligram
Nicotinic Acid, 8 Milligrams
Colloidal Iron Peptonate, 6.5 Grains

Dosage: Children, 1 teaspoonful 3 or 4 times a day. Adults, 2 teaspoonfuls 3 or 4 times a day.

Packages: Eight ounce and gallon bottles.

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COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., *Chairman*; Stanley Davies, M.D.; Arthur E. Martin, M.D., Elihu S. Wing, M.D., William P. Buffum, M.D.

The Council on Foods and Nutrition and the Council on Industrial Health of the American Medical Association, have recently issued a statement regarding nutrition in industry. Among the important recommendations is "It is urged that the plant management leave to the plant physician the responsibility for deciding where the distribution of pharmaceutical preparations of vitamins and minerals is or is not to be adopted as a remedy for correcting inadequacies in workers' diets." "It is further resolved that the office of the Council on Foods and Nutrition be prepared to provide physicians in industry with all pertinent information relating to the evaluation of distributing multivitamin preparations as a means of correcting inadequacies in workers' diets." "The Council on Industrial Health recognizes the important effects of nutritional deficiencies on the health and productivity of the workers. The Council is of the opinion that medical supervision to the extent of

1. Guiding management and furnishing suitable in-plant feeding facilities and dietaries.
2. Counseling with the workers in the prevention of nutritional deficiency states is a function of Industrial Health.

The Council is of the further opinion that the treatment of nutritional deficiency states is a function of GENERAL MEDICAL PRACTICE."

The Meeting in the Rhode Island Medical Library last month, of the Rhode Island Society of Industrial Physicians and Surgeons, was a notable event.

The field of Industrial Health was exceptionally well covered and was diversified enough to hold the interest and attention of all those associated with Industrial Health in any way.

It was exceedingly gratifying to note the large number of industrialists who attended the lecture by Louis Schwartz, Medical Director United States Public Health Service on Occupational Dermatoses in Rhode Island industries.

The Meeting was also highlighted by the appearance of Dr. C. O. Sappington, Editor of "Industrial Medicine" and author of standard textbooks on Industrial Health as well as Dr. Orlan J. Johnson from the Council on Industrial Health, American Medical Association, who spoke on hospitalization and cash sickness insurance sponsored by industry.

The latter part of the program was a symposium on the reconditioning of disabled war veterans and their assimilation by industry, arranged by the Office of the Surgeon, Armed Services Forces, 1st Service Command. Reviews and abstracts of the more important papers will appear elsewhere in this and subsequent issues of the Journal.

Industrial Toxicology

Industrial physicians will do well to remind plant managers, personnel men, and others who are responsible for the welfare of the employees that with the advent of hot and humid weather, salt tablets should be placed adjacent to drinking fountains and instructions should be placed above them so that employees may replace salt lost thru excessive perspiration. The time was when this was not an important matter but with increasing humidity in Rhode Island summers, it deserves serious attention on the part of industrial physicians at the present time.

Industrial physicians are also asked to contribute short medical columns to the plant newspaper. If any publication is distributed by the various industries, the physician associated with that industry should have a health column in the paper and discuss such things as accident prevention, nutrition, the attention to minor injuries and a myriad of other subjects that can be briefly stated in general terms to drive home a lesson of good health to the worker.

Toxology of Solvents

Methyl chloride (Monochlormethane) is one of the chlorinated hydrocarbons and used in refrigeration in liquid form. Local effect very slight. General toxic effect very strong. It can be absorbed very quickly, eliminated very slowly, and death may occur without serious previous symptoms. Death is the result of respiratory failure.

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FRONT-LINE first aid... plasma, emergency operations under fire... cuts casualty rates astonishingly. Physicians of World War II constantly face sudden death to bring modern medical miracles to fallen troops. Harrying, the war doctor's life. Weary grinds. Respites rare. Perhaps only a few moments or so now and then... time off for a welcome cigarette. A Camel, most likely—favorite brand in the armed forces.* Camel, first choice for mellow mildness, for appealing flavor . . . in this war, as in the last, cigarette of fighting men.



● New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Sq., New York 17, N.Y.

1st in the Service

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BUY WAR BONDS STAMPS

DOCTORS AT WAR

Dear Doctor:

Rather than review your war activities this month I thought you might like to have a kaleidoscopic report of the AMA meeting and allied activities as I saw them. Left here with your delegate, Dr. Burgess, on June 10 and en route talked at length of you men at the war fronts. . . . Read letters Dr. Burgess had from Colonel Lawson in which he reported the 48th Unit was together again, back where they were stationed a year ago, and that Major Frank Cutts is now head of medical service. The Unit has handled Chinese battle casualties, and by now is probably much in the Burma campaign. . . . Also an interesting message received from Lt. Comdr. Bob Williams, recently elected a Fellow of the College of Physicians, and now a veteran of amphibious warfare in the Pacific with an increasing aversion of islands and atolls. . . We left New York at dusk and noted the ships anchored in the Hudson, including the famed Gripsholm, and we thought of the stories that boat has heard. . . . Sunday morning and Chicago. . . . At the station we meet Dr. F. Ronchese and taxi to the hotel where a long lineup forms in quest of rooms. . . . Off to church with Drs. Murdock of Meriden and Mongan of Somerville. . . . Then lunch with the Connecticut delegates, Drs. Murdock, Barker and Miller. . . . In the afternoon the meeting called by the new Council on Public Relations where we renew acquaintance with Dr. Adson of Minnesota, spearhead in the drive which won approval of such a Council a year ago, and a host of other MD's and executive secretaries. . . . Listen to report of Dr. Joseph Lawrence, with whom we have corresponded for several years in exchange of legislative problems of New York State and our own, as he explains functions of new Washington office of the AMA, stating it will aid the members of Congress and the various federal departments, and also that it will seek state medical organization of committees that will be fully informed of what is going on at the national Capitol. . . . Thence to a meeting regarding advertising in State journals, and finally to supper at the Ivanhoe with a Nebraska delegation.

Monday is registration day. . . . A hurried trip to the Stevens hotel where we purchase a book on the National Health Service proposed by the British authorities, and we take a quick survey of the technical exhibits . . . then back to the House of Delegates meeting at the Palmer House where Dr. James Paullin, retiring President, delivers a fine address calling in part for the suppression of petty jealousies which might destroy the ideals established by the AMA in the past 97 years. . . . His warning that there is already an annual deficit of 2,200 physicians calls forth a request that President Roosevelt or Congress act at once to change Selective Service regulations halting draft deferments for premedical students on July 1. . . . A stream of resolutions is poured into the hopper by delegates from the various State societies, and all are quickly dispatched to reference committees by the efficient Dr. Shoulders, speaker of the House. . . . The session skips the noon hour, and finally, after the voting of the distinguished service award to Dr. Dock we adjourn at 3 p.m. for luncheon which is enlivened by a discussion of the day's proceedings. . . . The evening is spent on informal conferences, and we retire with the news that our Dr. U. E. Zambarano has been re-elected as governor for Rhode Island of the American College of Chest Physicians.

On Tuesday we note the Chicago *Sun* editorializes on Dr. Kretschmer's presidential address wherein he deplored the fact that only 6,227 physicians have supported the National Physicians Committee, and thereby according to the *Sun,* "unwittingly paid tribute to the 169,000 doctors who have had nothing to do with it". . . . We visit the outstanding Abbott collection of paintings of Naval Medicine and marvel at the display of equipment provided on the emergency life rafts carried by war planes. . . . The House of Delegates again absorbs our time and attention as action is taken on the various resolutions, with California receiving scant support in its recommendation that the editor of the Journal of the AMA be replaced. . . .

Adjournment of the session permits attendance at a P & A meeting conducted in flawless manner by Dr. Lahey. . . . Much discussion of the intern-resident problem with General Hershey's directive regarding deferment offering a major issue. . . . Dr. Barton reports 54,096 MD's now in service, practically half of the men under 45 years in active practice. . . . It is reported there will be 6,440 available places for medical students in 1945, with 28% of the quota to be filled by the Army and 25% by the Navy, the balance to come from 4F's and women. . . . We meet Dr. Hayes, former Illinois Medical Society president, and learn that our fellow townsman and college classmate, Gael Sullivan, was most helpful to the profession when he was an aide to Mayor Kelley. . . . The annual secretaries' dinner in the evening brings out the largest attendance ever, and we listen with interest to Ben Read of California as he relates the work of his Washington office for the U. S. Public Health League established by the medical societies of the Far West, to Dr. Lawrence report on the plans for the AMA Washington office, to Rollie Watterson as he briefly reports on the new national Association of Physicians started under the Lake County (Indiana) medical society auspices, and to a general discussion of the work of the medical cooperative bureau which secures the state journal advertising. . . . We close the evening noting that the Chicago *Tribune's* war correspondent reported that an

continued on next page

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DOCTORS AT WAR

continued from preceding page

American corporal checking captured Germans in the Normandy area found that the prisoners want to come to America after the war, with most inquiries propounded about Toledo, Ohio, and Providence, R. I.

The technical exhibits at the Stevens claim our attention most of Wednesday. . . . We view the unusual and varied collection of the American Physicians Art Association which included contributions by our Dr. Ronchese of Providence and Dr. Henry Jones of Cranston. . . . Lunch with Dr. and Mrs. Maison of Chicago and friends, including Dr. and Mrs. Fallon of Worcester, who help us maintain our claims of New England superiority against those of California as advanced by Jack Hunton, and Nebraska as championed by Merrill Smith. . . . The war meeting in the evening where it is reported by military leaders that of the American soldiers wounded only 3 out of every 100 die in army hospitals. . . . Then for a stroll on the lakefront to escape the heat of the evening.

Thursday concludes the meeting of the Delegates and we join with the other New Englanders in acclaiming the unanimous election of Dr. Roger Lee of Boston as president-elect of the AMA . . . and personal felicitations go also to Dr. Lou Bauer of Long Island upon his election as a Trustee. . . . A cocktail party with genial Dr. Bouslog of Colorado as host and at which we meet the medical leaders of the southwest, is followed by dinner with the Ohio delegation and we discuss again the need for medical public relations with versatile and energetic Dr. Ed McCormick of Toledo, former exalted ruler of the Elks. . . . With Tom Hendricks, secretary of the Indiana Society, we view the musical "Let's Face It", and learn that Cole Porter developed his unusual timing as the result of piano playing in his youth when he had to make his melody audible above the pounding of the motor on a Lake Culver steamer. . . .

Headlines relative to the action of prominent orthopedists in rebuking Sister Kenny for her claims regarding the success of her method in combatting infantile paralysis greet us Friday as we start our final tour of the scientific exhibits. . . . Luncheon with Dr. Burgess prior to his departure homeward, and then we head for the Morrison where we are introduced to the membership of the American Association of Medical-Dental Bureaus. . . . Meanwhile we note with regret the conflict in meetings which prevents our hearing Dr. Ronchese present his paper before the Section on Dermatology. . . . Dinner in the evening with Captain Milton Lacy of Providence, and his wife, proves most enjoyable and a real reunion as we had not seen them in two years during which the Captain had served as officer-in-charge of V-mail in Egypt. . . .

Saturday and a heat wave. . . . We check out for Columbus, Ohio, where we arrive Sunday morning along with the hottest day in the past 18 years. . . . Dinner with Rev. F. J. Baeszler, with whom we served so many years in promoting the athletic program at Providence College, and then an auto ride of the city with a trip to the spacious Ohio U. stadium which recalls memories of days when we guided football teams across the eastern collegiate scene. . . . Charlie Nelson and George Scaville of the Ohio Medical Association take us in tow on Monday and we return to the atsmosphere of work. . . . Luncheon at the University Club where we renew acquaintance with Dick Azzling, now with Bordens, and we meet Belford Atkinson, assistant secretary of the Ohio Bankers Association. . . . A visit to the Capitol building and Rhode Island pride swells within us as we note a mural of our Oliver Hazard Perry making the Lake Erie crossing. . . . We learn that Governor Bricker understands medicine's problems, and while admiring his campaign work we express the opinion that Dewey would get the GOP nomination. . . . Dinner at Nelson's home

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They used to laugh at "FLYING MACHINES"

Remember the days when people scoffed at the "dreams" of a few men... dreams of the average American "taking to the air"? Year by year, increasing numbers of travelers... no longer chained to earth by fear and ignorance... whisk through the air and accept it as a regular part of life.

There were days, too, when people avoided MARGARINE. But that was yesterday. Fortified MARGARINE'S present vitamin A content, its nutritious American fats which provide the important unsaturated fatty acids, plus its increased palatability, sweetness, freshness and... ease of digestibility ... have made it an outstanding nutritious spread and cooking fat.

Prejudice against Fortified MARGARINE is as ridiculous as would be a prejudice against the modern airplane, for this energy-producing food is part of the seven basic food groups needed for good nutrition.

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DOCTORS AT WAR

continued from page 352

proves a grand rest after more than a week of hotel and restaurant life, and thoughts of family and home surge more forcefully to the surface.

Comes Wednesday again, and we head for the Ohio U. campus where we are the speaker at the morning session of the 8th annual conference of executives of State and local trade associations sponsored by the College of Commerce in cooperation with the Ohio Association of Trade Executives. . . . We recount at length the development and operation of the Rhode Island Cash Sickness Compensation Program, and then follows an exhilarating half hour of discussion by keen-minded executives representing the leading organizations of the State. . . . We are felicitated on our presentation, and then we sit back to enjoy excellent afternoon talks by President Howard L. Bevis of the University, Reed Vance of the Ohio Printers Federation, and Merrill Watson, president of the National Association of Trade Executives. A dinner meeting at which Carlton Matson, New York publisher, discussed "Business and Politics in 1944" rounds out a busy day, and we depart from Columbus on the night train for home and a resumption of our activities in your behalf in Rhode Island.

Your executive secretary,

John E. Farrell

MILITARY ANNOUNCEMENTS

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Lieut. Edward Medoff, MC, Carlisle Barracks, Carlisle, Pennsylvania

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Lieut. Harry E. Darrah, MC, APO 5444, c/o Postmaster, New York, N. Y.

Capt. Robert L. Farrell, MC, 01696211, APO 270, c/o Postmaster, New York, N. Y.

Capt. Duncan H. C. Ferguson, MC, Boston Area Station Hospital, Waltham 54, Massachusetts

Capt. I. Gershman, MC, Med. Det., 444th AAA Auto. Wpns. Bn., Suffolk Air Base, Westhampton Beach, Long Island, New York.

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Lieutenant Colonel Herman A. Lawson to Colonel





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'Dexin' also helps avoid disturbances that might otherwise interfere with the addition of other foods. Its high dextrin content (1) reduces intestinal fermentation and the tendency to colic and diarrhea, and (2) promotes the formation of soft, flocculent, easily digested curds. 'Dexin' is readily soluble in hot or cold milk.

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Available carbohydrate 99% 115 calories per ounce
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- compared with 0.8 from PHILIP MORRIS Cigarettes.

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- showed that when smokers changed to PHILIP MORRIS,
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may be obtained with either drug. Quantitatively, however, Atabrine is considerably more active than quinine. Very much smaller amounts are required to produce a comparable result. Atabrine has the advantage of producing fewer minor manifestations of intolerance than quinine. In therapeutic dosage, Atabrine rarely gives rise to any untoward symptoms. Inasmuch as Atabrine does not reach a high initial blood level at the beginning of treatment, it is advisable to give larger doses early in the disease. The scheme recommended by the Surgeon General of the United States Army is 0.2 Gm. every 6 hours for 5 doses, followed by 0.1 Gm. 3 times daily for 6 days, with a total of 2.8 Gm. in 7 days. Each dose should be accompanied by 1 Gm. of sodium bicarbonate. The usual dose of quinine is 2 Gm. daily for from 7 to 10 days or a total of 14 to 20 Gm.

Plasmochin, the third important antimalarial drug is characterized chiefly by its effect upon the gametocytes of *Plasmodium falciparum,* a property which it shares with no other drug. It is of interest from the public health standpoint. In localities where it can be administered at frequent intervals to the entire population, it is capable of greatly reducing or eliminating the infection altogether. The dose required to prevent the transmission of malaria to mosquitoes is only 0.01 Gm. twice weekly or approximately 0.0004 Gm. per Kg. of body weight per week. This amount of Plasmochin produces no symptoms of toxicity. In addition to its effects upon the gametocytes, Plasmochin in larger dosage also destroys the trophozoites of all three species of malarial parasites, although the dosage required is such that toxicity is frequently encountered. For the treatment of clinical malaria, therefore, Plasmochin is definitely inferior to both Atabrine and quinine and should not be used for this purpose.

Although cinchona and its derivative, quinine, have been used in the treatment of malaria for about 300 years and Atabrine for more than 10 years, little was known about the manner in which these drugs accomplished their dramatic results in cases of clinical malaria. Recent studies of *Plasmodium knowlesi,* a parasite grossly analogous to the human malarial parasite but which causes a malaria-like disease in certain species of monkeys, have shed considerable light on the mode of action of antimalarial drugs. It has long been known that concentrations of Atabrine or quinine analogous to those obtainable in human therapy have little destructive action on the trophozoites or the gametocytes of the malaria parasite.

In a series of investigations carried out at the University of Tennessee and at the University of Chicago, it was found that the blood of monkeys infected with *Plasmodium knowlesi* loses its fluidity and tends to become separated into serum and clumps of cells. When a trophozoite enters a red cell, the resultant injury causes the red cell to become coated with a fibrin-like sticky substance. The function of this coating apparently is to cause the parasitized cell to adhere to the phagocytic cells lining the capillaries of the liver, spleen and bone marrow. In this way parasitized cells are engulfed and removed from the circulation. However, in monkey malaria this fibrin-like coating on the surface of parasitized cells causes them to adhere to each other and to form clumps which contain not only parasitized cells but unparasitized cells which are caught in the meshes of the clumps. The clumps so formed may be many times the size of the phagocytes and, therefore, cannot be engulfed by them. These clumps also reduce capillary circulation markedly by preventing streamlined blood flow and by mechanically plugging small capillaries.

In monkey malaria this impairment of capillary circulation seems to be responsible for most of the symptoms of the disease. If infected animals are kept heparinized, the sticky coating does not form on the parasitized red cells, clumping or sludging of the blood does not occur and the parasitized cells are not taken up by the phagocytes since they do not adhere during passage through the capillaries of the internal organs. Under such conditions animals do not have fever and do not show any symptoms of illness until the proportion of parasitized cells to normal cells has reached such a point as to severely impair the oxygen carrying capacity of the blood, at which time the animals suddenly collapse and die of anoxemia.

Within a few hours after Atabrine administration has been started in malarious monkeys, a striking change can be seen in the blood. The clumps of cells begin to break up and streamlined blood flow is restored. In contrast to the action of heparin, however, the fibrin-like coating on the cells remains to some extent at least and the parasitized cells which are now circulating singly are removed by the phagocytes. It must be pointed out that this process, while occurring in monkeys, has not been observed in detail in human malaria although it seems fairly certain that the same or closely similar chain of events takes place. At present, it

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The name to remember!



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BACK THE ATTACK...WITH WAR BONDS

MALARIA

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seems likely that this sludging of the blood is responsible for some, at least of the symptoms of clinical malaria and that the beneficial effects of Atabrine and quinine may be due, in part at least, to providing conditions under which cells with their engulfed parasites may be removed efficiently from the circulation.

Although an effective treatment for malaria has been available for 300 years; although the causative agent of the disease has been known since Laveran's discovery of the parasite more than 50 years ago, and although the transmission of malaria has been understood for 40 years since Ross incriminated the mosquito, wide gaps in our knowledge of the epidemiology of malaria, the life history of the parasite and the mode of action of antimalarial drugs have hampered productive research until recently. Despite this newer knowledge and despite the enormous new interest in malaria stimulated by the war, the eradication of this worldwide disease presents problems of such enormous complexity that there is little hope that its strangle hold on the throat of mankind will be broken within the foreseeable future.

Summary

A. Epidemiology and clinical manifestations of malaria vary widely throughout the world. These differences are due to variations in three principal factors.

1. Differences in the nature and habits of species of anophelies. The factors which cause an anopheline to be a good vector are:
   (a) The mosquito must be susceptible to the malarial infection.
   (b) It must bite human beings readily.
   (c) Its longevity must be sufficient to permit the full cycle of development of the parasite in the mosquito's body.
   (d) The species must be present in sufficient numbers.
2. Variations in the degree of immunity possessed by the human inhabitants of different parts of the world influence the clinical manifestations of malaria.
3. Strains of malaria parasites have been isolated which differ in their response to antimalarial drugs and in the severity of the symptoms which they produce.

B. Recently acquired knowledge of the malarial parasite explains:

1. Why malaria sometimes relapses after adequate treatment.
2. The latent period after infection during which transmission by mosquito or blood transfusion cannot take place.
3. Why antimalarial drugs act as suppressives and not as prophylactics.

C. The mode of action of antimalarial drugs is, in part at least, an indirect one.

INDUSTRIAL HEALTH NOTES

continued from page 349

Symptoms: Headache, nausea, vomiting, prostration, ataxia, rapid pulse, hypotention, cyanosis and coma.

Subacute and chronic symptoms consist of anorexia, abdominal distress, pain, diarrhea, psychic disturbances and delirium.

Treatment: Glucose, sodium bicarbonate by mouth or enemata, oxygen inhalations, injections of caffeine, and digitalis if necessary.

In industry, physicians should be on the watch for chronic poisonings or subacute cases where refrigeration equipment has a tendency to leak or otherwise allow methyl chloride to escape. Some cases have recovered in one or two weeks. Most cases die if symptoms are at all severe or prolonged.

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ANNUAL REPORTS . . . 1944

LIBRARY COMMITTEE

The Library has functioned as usual, during the past year, although there was some decrease in the number of visitors, due undoubtedly to war conditions. In contrast, the number of inquiries by telephone has markedly increased. These requests for information come from the laity as much as from the profession, and the replies to them occupy a considerable part of the time of the Staff of the Library, and it is evident that the service given is of increasing value to the entire community.

The details of the operation of the Library follow, being necessarily largely statistical.

Number of visitors, 1295.

Journals received, by subscription and exchange, 147.

Books received, 226. Of these some were purchased, some were sent to the Rhode Island Medical Journal, for review, and others were gifts. The total number of books in the Library on April 25, 1944 was 33,502. This figure does not include pamphlets and reprints, of which there are a large number.

The number of books and periodicals catalogued to date is 22,043. It is to be regretted that it has not been possible to extend this work to the pamphlets, some of which are rare and valuable.

Gifts.

C. J. Smith, D.M.D. A complete file of The Dental Cosmos.

Books from the following Fellows: H. H. Armington, P. P. Chase, C. L. Farrell, N. D. Harvey, R. S. Phillips, R. S. Wilcox.

Journals were received from F. V. Corrigan, L. I. Kramer, J. E. Mowry, F. Ronchese, E. Vieira, S. A. Welch.

Herbert C. Partridge, m.d., *Chairman*

Samuel Adelson, m.d., Adolph W. Eckstein, m.d.

COMMITTEE ON MEDICAL ECONOMICS

Your Committee's activities have been confined to meetings with the State Unemployment Board for discussion of the operation of the Cash Sickness Compensation Act in so far as it affects the Medical Profession.

There have been three of these meetings. The first was held at the Medical Library December 15, 1943 with Governor McGrath present. At this meeting your Committee asked for the clarifying of various questions of the Reporting Cards and made suggestions relative to the Board's having Examiners in various parts of the State for the convenience of claimants the Board wishes to examine. It also proposed the appointing of an Advisory Committee of Medical Men to confer regularly with the Board. This proposal was heartily seconded by Governor McGrath. This Committee consisting of— *Providence:* Herman C. Pitts, M.D., Chairman, Lucius C. Kingman, M.D., Alex M. Burgess, M.D.; *Pawtucket:* G. Raymond Fox, M.D.; *Warren:* Arcadia Giura, M.D.; *Newport:* Robert Bestoso, M.D.; *West Warwick:* Royal C. Hudson, M.D.; *Wakefield:* Salvatore P. Turco, M.D.; *Westerly:* Fernald C. Fitts, M.D.; *Woonsocket:* James M. McCarthy, M. D.; was appointed before the next meeting which was held at the Medical Library March 8, 1944.

The discussion was rather general at this meeting. Considerable time was spent over the problem of certifying to disability. The Doctor is required to certify that the patient is unable to perform any labor, is in other words totally incapacitated. The Doctors present felt that the question should be reworded, but no agreement was reached.

The creation of Examining Centers in parts of the State outside Providence was promised by the Board if the Legislature passed the Amendment increasing the Sickness Administrative Fund from one to three percent.

The third meeting of the Medical Advisory Committee with the State Unemployment Compensation Board was held in the offices of Board on West Exchange Street. The forms used in reporting illness were again under review and some minor changes suggested. The fact that certain Doctors made a practice of charging a fee for filling out blanks for Sickness Compensation was discussed. The Board agreed to make out a list of the men and submit it to the Rhode Island Medical Society for action.

It was voted to have at least four and probably six meetings of the Advisory Committee and the Unemployment Compensation Board each year, so that the Medical Profession could present complaints and be kept in touch with the problems arising in the Administration of the Act.

Herman C. Pitts, m.d., *Chairman*

Lucius C. Kingman, m.d., Alex M. Burgess, m.d., Michael H. Sullivan, m.d. (*ex officio*), William P. Buffum, m.d., (*ex officio*).

COMMITTEE ON EDUCATION

Herewith is submitted the report of the Committee on Education of the Rhode Island Medical Society for the year commencing June 1, 1943.

The fifteen-minute radio talks which have been now running continuously since December 1938, over Station WPRO every Sunday afternoon at 1:30 P. M. until November 20, 1943 when the time was changed to every Saturday afternoon at 1:45 P. M., have been continued without letup, and it is apparent from the many letters and requests for copies of talks that our audience is a growing and enthusiastic one. Forty-six radio talks have been given in the past year of which the following is a list:

212. May 23—Heat and Massage in Painful Joints, Dr. Roland Hammond.
213. May 30—1946—The Centenary of Surgical Anesthesia, Dr. Albert H. Miller.
214. June 6—War Time Health Problems, Dr. Wm. P. Shields.
215. June 13—Peptic Ulcer in War-Time, Dr. Eugene A. Field.
216. June 20—The Rhode Island Doctor in War, Dr. Halsey DeWolf.
217. June 27—The Heart Disease of Children, Dr. Banice Feinberg.
218. July 4—The Training and Work of a Nurse's Aid, Mrs. John L. Thornton.
219. July 11—Cerebral Accidents (Shock), Dr. Laurence A. Senseman (Lincoln).
220. July 18—Birth Marks, Dr. William B. Cohen.

continued on next page

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221. July 25—Low Back Pain, Dr. G. Edward Crane.
222. Aug. 1—Some Strange Beliefs Regarding the Eye, Dr. Raymond F. Hacking.
223. Aug. 8—Recent Advances in the Treatment of Heart Disease, Dr. Henry L. C. Weyler.
224. Aug. 15—Common Sense Care of the Teeth, Dr. Charles F. McKivergan.
225. Aug. 21—The Blue Cross—After Four Years, Mr. Stanley H. Saunders.
226. Aug. 28—The Medical Aspects of Cash Sickness Compensation, Dr. Hugh J. Hall.
227. Sept. 4—Infantile Paralysis, Dr. Edward McLaughlin.
228. Sept. 11—The Pre-school Examination, Dr. Harold G. Calder.
229. Sept. 25—Appendicitis, Dr. Joseph L. Belliotti.
230. Oct. 2—Industrial Medicine, Dr. Charles L. Farrell (Pawtucket).
231. Oct. 9—Diabetes Mellitus, Dr. Raymond Luft.
232. Oct. 23—Occupational Deafness, Dr. Jay N. Fishbein.
233. Oct. 30—Tonsils and Adenoids, Dr. Lee G. Sannella.
234. Nov. 6—Pharmacy and the War, Mr. Albert W. Claflin.
235. Nov. 13—The Role of X-ray Therapy Today, Dr. Philip Batchelder.
236. Nov. 20—Gallstones, Dr. Harry Triedman (Pawtucket).
237. Dec. 11—Experiences of a Hospital Intern, Dr. Harold S. Barrett.
238. Jan. 8—Your Heart After Fifty, Dr. Clifton B. Leech.
239. Jan. 15—Wartime 'Nerves', Dr. Walter C. Weigner.
240. Jan. 22—Asthma and Hay-fever, Dr. Reuben Bates.
241. Jan. 29—The Magic of Cystoscopy, Dr. M. A. Chapian.
242. Feb. 5—How Long Will We Tolerate Tuberculosis? Dr. John C. Ham.
243. Feb. 19—The Eyes After Fifty, Dr. Frank W. Dimmitt.
244. Feb. 26—Sinus Disease, Dr. Francis L. Burns.
245. March 4—Goitre, Dr. Louis I. Kramer.
246. March 11—Post-War Plans for Medicine, Dr. Harmon P. B. Jordan.
247. March 18—Cancer in the Female, Dr. Ralph DiLeone.
248. March 25—Penicillin, Dr. William P. D'Ugo.
249. April 1—Disease Prevention in Childhood, Dr. John Langdon.
250. April 8—The Significance of Abdominal Pain, Dr. Daniel D. Young.
251. April 15—What is the Truth About Cancer? Mr. John E. Farrell.
252. April 22—Anesthesia Through the Years, Dr. Albert H. Miller.
253. April 29—The Significance and Purpose of a Chest Clinic, Dr. Halsey DeWolf.
254. May 6—Modern Pharmacy, Dean W. Henry Rivard.
255. May 13—Your Teeth and Your Health, Dr. Charles F. McKivergan.
256. May 20—Scarlet Fever, Dr. D. W. J. Bell.

Seven hundred and fifty-five letters have been received by your committee from the general public requesting copies of the above talks, and this same number have been mimeographed and mailed to the radio audience. There are six who call for a copy of each lecture. This regular mailing list includes Miss MacDonald at the Public Health Library, Miss Carberry of the Rhode Island State Department of Social Welfare, Mr. Dunham from the Red Cross, Mr. James E. Smith of the United States Fidelity and

Guaranty Company and Mr. John Farrell, Executive Secretary of the Providence District Society. Many of the letters received contain not only requests but expressions of appreciation.

It is the belief of your committee that these radio talks should again be continued as in the past. We wish to express our thanks to Miss Dickerman and her associates and to Mr. John Farrell, Executive Secretary of the Providence District Society, for the work and assistance which they have rendered to the committee. We wish also to express our thanks to Station WPRO for its courtesy in giving us time, to Blanding & Blanding, Inc. for the advertising which has been freely contributed, and to the many members of the profession who have by their cooperation and suggestions been of invaluable aid.

JESSE P. EDDY, III, M.D., *Chairman*

JOHN LANGDON, M.D., G. RAYMOND FOX, M.D., MICHAEL H. SULLIVAN, M.D., (*ex officio*), WILLIAM P. BUFFUM, M.D. (*ex officio*).

COMMITTEE ON PUBLICATIONS

In July, 1943, as part of the re-organization program adopted by the Society, the *Providence Medical News*, official publication of the Providence Medical Association, was discontinued and its editor, John E. Farrell, was named as managing editor of the RHODE ISLAND MEDICAL JOURNAL. By this arrangement the JOURNAL obtained the services of a full time business manager, thus relieving the editor-in-chief of this phase of the work incidental to our monthly publication.

Plans for the re-organization of the JOURNAL were drafted in the summer of 1943, and were first put into effect with the August issue. The format was redesigned, new sections were added to the JOURNAL, and the best features of the *Providence Medical News* were continued. At the same time a study was made by the managing editor of the possibility of securing additional advertising.

In the past ten months the JOURNAL has forged ahead as one of the outstanding medical publications. It has increased in size from 36 to 56 pages, and in circulation from 800 to approximately 1350. It has been expanded to serve as the official publication also of the Rhode Island State Dental Society. Its excellent scientific articles have attracted attention, and likewise its editorials, many of which have been reprinted in other medical publications.

The JOURNAL has been sent to every member serving with the armed forces and every effort is made to keep this mailing list accurate in spite of the many changes in assignment of these doctors. Letters from members in distant lands indicate to some extent the value of the JOURNAL, and no little praise is due to the editorial staff for its excellent reporting of the work of our doctors at war.

The Committee on Publication has been faced with a financial problem which it hopes may be eliminated in another year. Contracts for advertising for the present year were renewed in the Fall of 1943 at the rates which had been charged for many years. However, the costs of printing the JOURNAL mounted because of labor conditions, and with the expansion in size and circulation the operating expense of the publication leaves little, if any, profit at the present time. The Committee recognized that until the JOURNAL had been completely re-organized the advertising rate schedule could not justifiably be changed. Therefore it is not until June 1, 1944 that the advertising charges will be advanced, effective on all present contract renewals and on new advertising. It is to be hoped that a year hence the JOURNAL will have continued its excellent expansion, and that it will also be assured of an income capable of meeting all its operating costs.

The Chairman of the Committee in this, his final report, desires to express to Mr. Farrell and to Dr. Chase his

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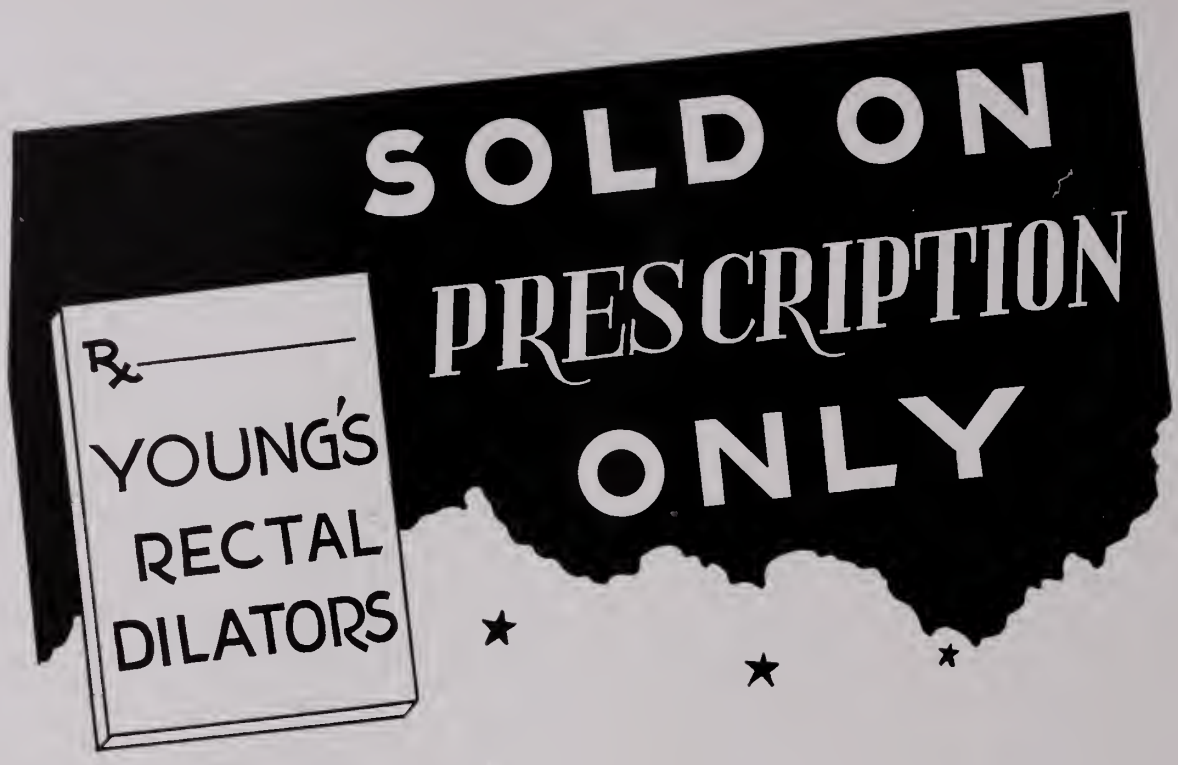
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COMMITTEE ON PUBLICATIONS

continued from page 363

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ALFRED L. POTTER, M.D., *Chairman*

JOHN F. KENNEY, M.D., AUGUSTINE W. EDDY, M.D., MICHAEL H. SULLIVAN, M.D., WILLIAM P. BUFFUM, M.D.

COMMITTEE ON PUBLIC LAWS

The Committee on Legislation continues to view with concern the annual introduction of health legislation of dubious character in the General Assembly, and the Committee finds its task increasingly difficult to discourage the practice whereby such measures are given quasi-support by persons with apparently little concern for the high standards of health that have been established.

This situation was again brought to the fore during the past session when such measures as one licensing the practice of naturopathy, a theory with no authoritative support, was passed by the House, and an act providing that school superintendents should inaugurate programs for the examination of the legs and feet of children by podiatrists exclusively to detect infantile paralysis reached the House calendar.

The Committee deplores the inactivity on the part of the State Department of Health, and the various municipal health departments when such legislation is presented in the Assembly. That the medical profession should have to assume the major role in protesting the passage of health legislation inimical to the best interests of the public is, in the opinion of this Committee unfair. The members therefore urge that the House of Delegates take definite action in seeking wider support throughout the State in the surveillance of health legislation.

A summary of the more important health measures passed by the Assembly follows:

An appropriation of $25,000 was made for the hospitalization of wives and children below the grade of commissioned officer in the armed forces. This sum was requested by the State Department of Health to augment the program of Emergency Maternal and Infant Care established by the Federal government, and it is to be utilized particularly to extend hospital care to children over one year of age who are excluded under the federal program.

An act permitting druggists to refill prescriptions containing small amounts of certain narcotic drugs.

An act creating a commission of not less than five persons, appointed by the Governor, to study the needs of the physically incapacitated persons who are unable to earn a living, and to recommend any necessary remedial legislation to the next session of the General Assembly.

An act providing that in any year in which the State appropriates $200,000 for the support of the Charles V. Chapin hospital, the hospital shall admit any patients from any city or town without charge to the city or town.

An act appropriating $10,000 for the suppression or extermination of mosquitoes.

An act continuing for one year the special commission surveying the State and municipal health laws and carrying an appropriation of $5,000 to be added to the $3,000 appropriated last year and providing that 16 of the 18 members be paid $10 per meeting.

An act increasing from one to three per cent the portion of contributions to the Cash Sickness Fund that may be used for administrative purposes.

An act permitting the removal of a body from a public highway without need of consent from the medical examiner where there is no evidence of death by violence.

A Juvenile Court act with an amendment to the original form suggested by the State Medical Society to specify that examination of children be made if desired by a licensed physician who is expert in physical diagnosis or in neuro psychiatry.

Legislation Not Enacted

An act to regulate the practice of neuropathy. Passed the House but not reported out of the Senate committee on judiciary.

An act providing that no funds made available under the proposed law providing for State-paid Blue Cross membership for State employees shall be paid to any corporation which does not recognize the right of osteopathic physicians to practice on a parity with medical graduates, or the rights of osteopathic hospitals with other hospitals. Passed the House.

An act appropriating $40,000 to extend the Blue Cross membership to State employees receiving less than $2,500 annually. Passed the House.

A joint resolution creating a 5-member commission to study the feasibility of establishing blood plasma banks in the counties of Rhode Island which would be free to all who need them and empowering the Governor to put into effect recommendations of the commission after adjournment of the Legislature if he deems it expedient to do so. Passed the Senate.

An act creating an industrial board on safety and health within the State department of labor. Passed the House.

A resolution requesting any present or future State post-war planning agency to consider the establishment of a State general hospital in Woonsocket. Passed the House.

An act compelling employers of five or more persons to provide a medical or surgical chest meeting standards of the Director of Labor, and employers of 500 or more to maintain an accident room under a registered nurse or specially trained person. Passed the House.

An act making every employer subject to the provisions of the Cash Sickness law, instead of employers of four or more. Passed the House.

An act appropriating $1,000 for conducting a cancer control program in the State's high schools. Passed the House.

An act subjecting to provisions of the Cash Sickness law religious, charitable, scientific, literary and educational organizations now exempt. Passed the House.

Through the executive office of the Society a close check is maintained on all health legislation introduced in the Assembly, and copies of acts and reports on them are available to any members.

WILLIAM H. FOLEY, M.D., *Chairman*

LEWIS B. PORTER, M.D., HERMAN C. PITTS, M.D., HENRY E. UTTER, M.D., EMERY M. PORTER, M.D., EARL F. KELLY, M.D.

COMMITTEE ON SOCIAL WELFARE

Your committee has had several meetings during the year to discuss the problems of medical care which fall within the scope of the Rhode Island Department of Social Welfare. The latter through the Division of Public Assistance instituted a plan of assistance for medical care to be available to all persons who are in need. This plan is being tried for a six month period on an experimental basis in the town of East Providence. It declares to provide assistance to persons in the form of a money payment sufficient to meet their needs which includes a consideration of the cost of medical care. It is open to all persons whose income and

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SOCIO-ECONOMIC PROBLEMS OF DENTISTRY

continued from page 341

several plans for the provision of dental care for children. Approval of one such plan (THE TRIER PLAN) not only is on the record, but it was widely publicized in newspapers, lay magazines and professional journals. It was laid before the health authoritities of the city, the state and the nation. No cooperation or positive action was forthcoming from any of these sources. Other plans have been presented for the care of the indigent or semi-indigent. None of these were deemed practical although several received the "Kiss of Death" by being approved "In Principle."

Various sociologists, health writers, and others with non-dental background in advocating various plans seem to regard dental disease as one that can be cured by a miraculous serum. Perhaps one day caries will be so treated. In the meantime, a program calling for the provision of minimum standards of good sound dental care, together with a program of prevention for children is needed. Before such a program can be established the necessary financial assistance is also needed.

The responsibility for the provision of dental care to all is a divided one. The profession, by its record shows that it stands ready to cooperate with the government. Despite this fact, non-dental writers, usually men in administrative positions, accuse the profession of "charging too much money for their services," and of "blocking constructive planning by a negative attitude." The concern felt by the profession over dental neglect and the inability of the masses to obtain adequate dental care is a sincere one. If some elements within the profession are opposed to any form of health insurance that is their privilege as citizens. The rest of us, similarly, have the right to offer to cooperate with the government in any reasonable effort to provide such care for those who need it. The provision of dental care for the needy does not mean that those rendering the service must be punished financially. Any such plan must provide the dentist with a fair standard of living. If the profession unites on this problem, the profession and its individual members will not suffer. But our present hit or miss system continues.

Why doesn't our population purchase dental service today?

Fear, economics, lack of education, and the disagreeable nature of the service itself combine to prevent our population from purchasing dental services today.

Many opinions can be expressed when the question "Why does not our population purchase dental health service today?" is answered. I believe the basic reason is that the majority of our population disregards the necessity of continuous care for their bodies. Lack of knowledge or the ability to pay for such care does not answer the question, for there are many who possess both and make use of neither. Continual education from the cradle to the grave will always be necessary.

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COMMITTEE ON SOCIAL WELFARE

continued from page 365

resources are not sufficient to enable them to meet the cost of medical care. It provides free choice. A schedule of fees is stated which the division of Public Assistance will pay. Any cost over and above this will have to be satisfied in some other manner. The appointment of a Medical Advisory Committee to provide advice in regard to standards is contemplated.

In consideration of the plan the committee has felt that;

(a) There must be aid to the indigent.

(b) There are probably some families or persons who are self-supporting in all matters except their ability to provide medical care during an illness.

Some consideration must be given to these people whom we feel constitute a group of medically indigent. A clear definition of medically indigent is desirable to prevent abuse of the plan by the unscrupulous.

The committee discussions disclosed many opinions, some of which follow.

It is unfortunate that the plan as constituted grants many privileges and demands no significant obligation.

It would appear that the plan can be wielded by the recipients contrary to the intent of the administrators.

Any plan which attempts to solve the problems of medical care should specify that the privileges are granted only when the immediate medical problem is not contrary to the public health laws of the state.

The wisdom of instituting a plan of this nature at a time when the physicians are greatly over-burdened and, naturally, are unable to satisfy all the demands of all the people may be questioned. It could place the physician in a position where he might be criticised for not administering all the care that a state-sponsored client might demand. Such criticism might not be recognized as wholly unwarranted and consequently would injure the individual doctor or the entire profession.

The committee has given much serious discussion to these needs which border on the so-called socialization of medicine. It is not prepared to recommend that the state assume too great a role in the distribution of medical care.

The shifting of essential responsibilities is not to be considered character building. The effect of an increasing attempt to relieve individuals of their responsibilities to themselves and their families may produce a greater demoralizing effect upon the character and stability of the present and future generations than the solution of a moot problem warrants.

The committee is aware of the sincerity of the local social welfare leaders and has been aiding them in their efforts to improve medical care to needy persons. It does, however, feel a responsibility to the community and the profession and is not prepared to discharge this responsibility lightly.

There is an urgent need for greater interest by the members of the profession in the problems associated with medical care to the needy. The future procedures will be based on present experiments. Improvement in these procedures should be made through the committee at your suggestions. Suggestions and active participation in meetings will be welcomed by the committee from any and all physicians.

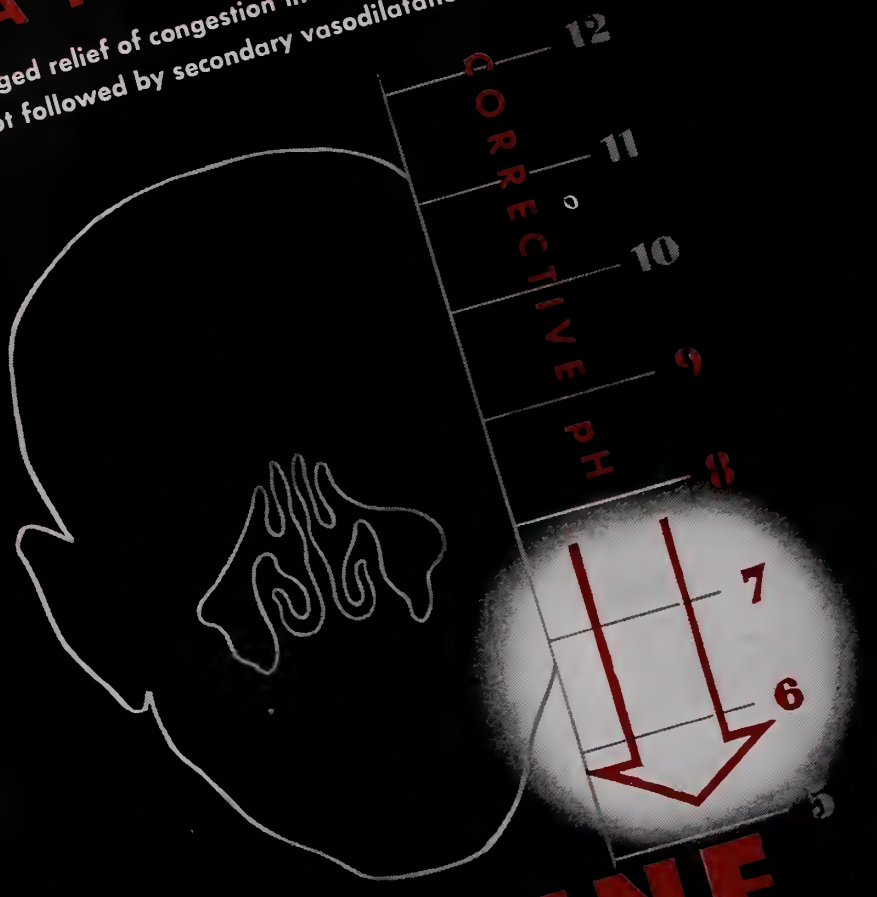
PETER F. HARRINGTON, M.D., *Chairman*

WILLIAM P. BUFFUM, M.D., ALEX M. BURGESS, M.D., HARTFORD P. GONGAWARE, M.D., NORMAN M. MACLEOD, M.D., EARL J. MARA, M.D., GEORGE L. YOUNG, M.D., FRANCIS E. HANLEY, M.D.



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BUTLER HOSPITAL CENTENNIAL ISSUE

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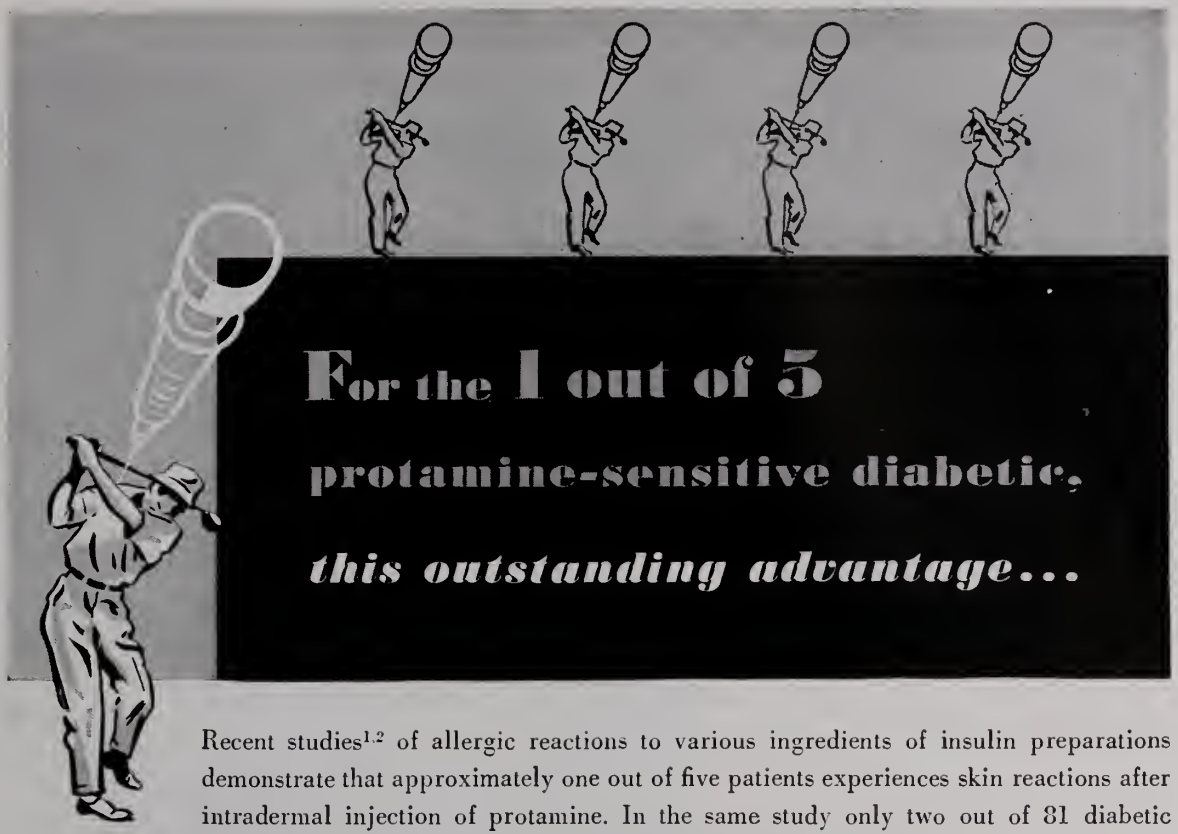
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(1) Page, R. C., and Bauman, L.: J.A.M.A. 124:704 (March 11) 1944. • (2) Bauman, L.: Bull. N. E. Med. Cen. V:17-21 (Feb.) 1943. • (3) Bauman, L.: Am. J. Med. Sc. 198:475 (Oct.) 1939, ibid. 200:299, 1940. • (4) Duncan, G. G., Diseases of Metabolism, Phila., Saunders Co., 1942, p. 782.

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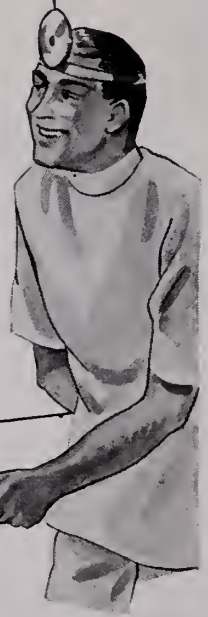
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVII AUGUST, 1944 No. 8

BUTLER HOSPITAL CENTENNIAL CELEBRATION

May 10, 1944

Opening remarks by WALTER A. EDWARDS, *President of Butler Hospital*

THE BOARD OF TRUSTEES and the Superintendent of Butler Hospital welcome you to this celebration of its centennial. We deeply appreciate your attendance. Indeed, nothing could more appropriately commemorate the Hospital's past or be a happier augury of its future than the interest and the friendship which are evidenced by the presence of so many of you at a time when travelling is so uncomfortable, when there is so much to be done and there are so few to do it and when men await with impatience, with apprehension and with hope the arrival of one of the critical moments of history.

As we look back over the century of Butler Hospital's existence, we see that it has contributed to the steady progress which has been made in the treatment of mental disease and to the improvement of the layman's attitude toward mental disease. There is every reason to believe that in the next century it can contribute to still further advances in these respects. But for it to do so most effectively, adaptation to changed conditions and some redefinition of function will undoubtedly be necessary. Upon its establishment Butler Hospital was the only institution in the state which cared for the mentally ill. To-day its work is only part of a broad and developing program. At the present time government has occupied a large portion of the field which was formerly occupied exclusively by private charity. When these changes, and other changes, are taken into account, it is apparent that a private endowed hospital, like Butler Hospital, will face in the next century the problem of adapting itself to those changes. I hope that, in facing this problem, those charged with the Hospital's administration may think clearly and may not be deterred from action by a failure to realize that change is not something to be deplored and that without the challenge of new conditions man would perish from the decay of inertia.

In the last century Butler Hospital has been fortunate in more than one instance in receiving the devoted service of members of successive generations of a family. One such instance has been unique. In that instance a father, his son, his grandson and his great grandson have all been benefactors of the Hospital. Its establishment was made possible by a bequest from Nicholas Brown. His son, John Carter Brown, served as one of its trustees for twenty-three years and then as its president for seven years. His grandson, John Nicholas Brown, served as one of its trustees for sixteen years until his untimely death. His great grandson, John Nicholas Brown, is now an active and respected member of its Board of Trustees. It is peculiarly fitting that he should be the chairman of the committee on the celebration of the Hospital's centennial. To him I now turn over the conduct of this meeting—Mr. John Nicholas Brown.

Remarks by JOHN NICHOLAS BROWN, *Chairman, Butler Hospital Centennial Celebration Committee*

IT IS with a peculiar emotion that I stand before you today in the capacity of Chairman of the Committee on Arrangements for the One Hundredth Birthday of the oldest hospital of any kind in the State of Rhode Island, and I do so fully cognizant of the fact that, although one hundred years old this year, Butler Hospital is at least one hundred years young in its attitude towards the future.

In 1844 Cyrus Butler, whose name this Institution bears, made possible the erection and creation of this Institution by the gift of $40,000 with the following provisions: that another $40,000 should be collected from the community and that that $80,000 should be added to the bequest of Nicholas Brown. Apparently the words of Nicholas Brown's Will (which I will quote to you in a moment) struck such a sympathetic chord in the heart of Mr. Butler that he was led to make the gift, which in fact has made this great Institution possible.

You will remember, perhaps, that my great-grandfather stated in his Will that he would leave his bequest "for that unhappy portion of our fellow beings who are by the visitation of Providence deprived of their reason, so that they may find a safe retreat, and be provided with whatever may be

continued on next page

conducive to their comfort and to their restoration to a sound state of mind", and that statesmanlike phrasing of the purposes of the Hospital, I believe, has been the lodestar guiding the whole development of this Hospital for the first one hundred years. As I review that one hundred year period, the termination of which we are celebrating today, it strikes me very forcibly, as I am sure it will you when you come to read in detail the history of the Institution, that there is one outstanding fact about Butler Hospital and that is the fact that probably no charitable institution elsewhere has ever been created with any more foresight and planning than this Hospital.

Let me recall to your mind that the Trustees, as soon as they had received the necessary sum of money, went to limitless pains first to find the proper superintendent, which they did in the person of Dr. Isaac Ray, then Superintendent of the State of Maine Asylum; and secondly, for the proper physical planning of the architectural membering of this Institution. You will remember that Dr. Luther V. Bell, then the Superintendent at McLean Hospital in Massachusetts, part of the Massachusetts General Hospital, was sent abroad and actually toured the countries of Europe for the purpose of studying the very latest in the plans for the creation of mental hospitals, and those plans which Dr. Bell brought back and which he supervised in the actual drawings, were finally published in an article in a magazine.

Amongst other things I shall mention two points stressed by Dr. Bell. The first was a radical departure for those days—the segregation of the patients into what Dr. Bell called communities, and hence we have in this Hospital, as those of you who have been through it will recognize, these wings, or wards, where there are corridors off of which come the actual rooms of the patients themselves.

Secondly, Dr. Bell emphasized, and the Trustees have always carried the idea on, the necessity for a hospital to have adequate fire protection. The original plans called for cisterns to be installed in the attic story over the different "communities" so that wash rooms could be supplied with water and also so that there would be ample fire protection. Through the first one hundred years the Trustees have seen to it that adequate fire protection be provided by means of adequate cisterns, pumps, and more recently by connection with the mains of the water system of the city. In that regard Dr. Bell emphasized and the Trustees accepted the necessity of having the buildings divided with proper fire partitions of brick, not only against those patients who were in a disturbed condition, but also against future fire hazard. So we emphasize at this time very briefly, that one point, that this Institution has always had in a peculiar degree, a planning, looking forward, forecasting of the future. That has been brought up to within a relatively short time by the creation by the Board of Trustees in 1941 of a committee called the Ways and Means Committee, which had Mr. Edwards as its Chairman, with Mr. Hartwell and the late Mr. Royal C. Taft as other members. Their report which looked into the full scope of the purposes and means of a mental hospital such as Butler Hospital was deemed so valuable by the Trustees that it was put into printed form and will for many years to come be a guide to those of us Trustees on whom rests the responsibility for the physical development of this great Institution.

I am particularly happy that Butler Hospital is able to avail itself of the peculiarly adequate faculties of the Chairman of the Ways and Means Committee, Mr. Walter A. Edwards, who is now the President of the Board of Trustees as Butler Hospital enters into the second century.

The foresight and planning of the Trustees does not exhaust, by any means, the planning which is an integral part of this Institution. From the very start the men in charge of the work of the Institution on the medical side—that is, the care of the patients themselves—have always been of very high and splendid character. From the days of Dr. Ray, our first Superintendent, we have always been the beneficiary of a series of superintendents in Butler Hospital who rank with their peers in the whole psychiatric and medical profession. I know that all of you agree that this long and distinguished line of doctors actually in charge of the work of the Hospital is crowned, as it were, by the presence in our midst since 1922 as Superintendent, and before 1922 on the staff, of our beloved Doctor Arthur H. Ruggles. There is no one anywhere, I am sure (and I speak without fear of contradiction) who has endeared himself, not only to the profession and to the country at large, but also especially to the community in which he has lived and served, than this great apostle of mental stability and health. We all stand today in affectionate regard of Dr. Ruggles at a time of happy celebration of an event which has been confidently looked forward to for a hundred years.

The Committee on Arrangements has had a peculiarly happy task in the preparation and the printing of a Volume entitled "A Century of Butler Hospital." This volume is a permanent memoriam, in this year of War, of a remarkable history and stewardship. At this time I want to thank the three contributors to this volume: Mr. William Greene Roelker, Director of the Rhode Island Historical Society who has written the larger part, entitled "A Layman's History"; and the other two whose splendid articles will challenge your interest, Dr. Gregory Zilboorg, and Dr. Ruggles himself.

THE CONTRIBUTION OF PSYCHIATRY TO DEMOCRATIC MORALE*

EDWARD A. STRECKER, M.D.

The Author. *Edward A. Strecker, M.D., of Philadelphia, Pa. President, American Psychiatric Association; Professor of Psychiatry, University of Pennsylvania Medical School; Consultant to the Surgeons General of the Navy and of the Air Forces.*

IN order to obtain a proper perspective on "The Contribution of Psychiatry to Democratic Morale" it should be remembered that in an area of the world much larger than these United States, exercises such as are being held by Butler Hospital today would not be permitted. If we met together and expressed our democratic opinions, we would have been consigned to concentration camps and no doubt, some of us would be standing at the receiving end of a firing squad.

During the early part of the first 100 years of the life of this hospice of healing and institution of culture, the chapters of Psychiatry's humanitarian era were still being written. The shameful pages of inhumanity to the mentally sick were still sad with human suffering and wet with human blood. Today we celebrate a century marked by many milestones of scientific and humanitarian psychiatric progress. It is highly fitting that we should mark these ten decades of psychiatric achievement at Butler Hospital which has contributed so signally to its attainment.

Long since, Psychiatry has abandoned its formulae of violence—its cells, its chains, its leg locks, its keepers and its whips once freely and cruelly used under the rationalizing cloak of the necessity of keeping patients from being unruly. Soon it was recognized that violence engenders violence and if kindly treated, mental patients would generally become responsive and well-behaved. The change was not too easily accomplished. There were very articulate objections and the warning was solemnly given that the patients would get out of control and probably take possession of the institution, no doubt locking the Superintendent and his Staff in the cells. Today, the use of the ancient instruments of Psychiatry — its weapons in the daily battles with mental patients—would be as archaic as would be transportation by the canvas covered wagons of prairie days or, more to the point, as bestial and archaic as is war.

Here is the first contribution of Psychiatry to democratic civilization. Technical genius may be employed as readily to fashion lethal and wantonly destructive machines as for constructive and culturally enhancing purposes. We must learn for all time, that the culturally outmoded formulas of war will no more succeed in solving global human problems than did the chains and whips of Psychiatry cure the ills of its patients. If we persist in our violence, then one day human civilization and its cultures will be dashed over the precipice into the abyss of barbarism. Twice during the short span of a quarter of a century we have been seriously close to the brink of the precipice.

Significance of Social Treatment

In the wards of this hospital as in every good mental hospital there is being carried out every day the successful operation of the practical workings of democracy. There are many criteria of mental disease, but the universal criterion is social. If anyone of us grossly over-estimates so-called personal rights and flagrantly disregards either in active or passive behavior the rights of others, then it is altogether likely that he will become a patient in a mental hospital. Here, irrespective of chemical, electrical or psychotherapeutic therapy, the social treatment is significant. The patient will progress from the disturbed section of the hospital where there is practically no recognition of each other's rights by the patients to the quieter and convalescent areas, only as he regains appreciation and regard for the rights of others. Recovery and re-instatement in his particular social niche is tantamount to a re-learning of the capacity of ceding in behavior, fallacious personal "rights" to other human beings.

Here is a lesson for democratic civilization and morale. I think it is not too much to say it is in a better delineation of this mutually held territory and in a wiser definition of the "me and thou" relationship that the survival of our democracy depends. After all, there are only a few valid personal rights. The right to protect one's life and property; the right to worship God according to the dictates of one's conscience; the right to think indepen-

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*An address delivered at the Centenary Celebration at Butler Hospital, Providence, R. I., on May 10, 1944.

dently but not always to translate thought into behavior. If we wish our democratic society to survive we must take into our hearts the lessons that mental patients are taught in this hospital. We must be less aggressive and vociferous about insisting on our "rights"; more quietly in earnest about fulfilling our duties.

Perhaps the platform of psychiatric democracy may be taken as a vantage point of departure for the inculcation of better human understanding into the personalities of human beings throughout the world. In the highest reaches of its practical aspects and aims and in its idealistic aspirations, it might be graphically pictured as a series of interlocking circles each including a segment of the others—and "I" or self circle; a family circle; a national circle, and finally, an international circle containing consideration for all fellow men regardless of distance, color or creed. If there could be such a democratic citadel in the hearts and souls of the majority of men then all the threats and wiles and promises of lustful dictators would never serve to storm its defenses and trap men into breaking an enduring peace.

Psychiatrists may justly lay claim to some understanding of the methods and dangers of isolationism. Every day we deal with an extremely proficient psychological isolationist — the schizophrenic. His symptoms are his defenses against the intrusion of reality and if needs be, he may bar intruders by feigning death in a katatonic stupor. Often the symptomatic defenses of the schizophrenic are so skillfully placed that not even the most carefuly planned treatment attacks—chemical, electrical and psychological—are successful in storming the citadel of fantasy. Many of these prisoners of thought continue to live in their lands of unreality for twenty, thirty, and indeed, a lifetime of years.

I think there is some kinship between our psychological isolationist and the political isolationists. In spite of the almost annihilation of time and space by technical science so that peoples once remote are now unbelievably close, national isolationists seemingly believe it feasible to erect an encircling Chinese wall; hide behind it and live successfully by subscribing to a code which might be expressed as follows: "We won't bother with foreigners. We don't want anything to do with them. Let them mind their own business and we will mind ours."

It would seem to me that the honors are with the schizophrenic isolationist. After all, although his fantasies are real to him, still they lack substance. Unlike the wall of national isolationism, the fantasy protection of the schizophrenic cannot be breached by economic and idealogical spearheads, nor can his mental territory be destroyed by bombs and shells. From its own experiences with psychological isolationism, Psychiatry is prepared to say to a democratic nation: Democracy cannot long survive in an atmosphere of rigidly restricted nationalism and if it blindly insists on such a course, it will result inevitably as in the case of the mental patient in inanition, apathy, destruction and spiritual death.

The Threat Against National Morale

Morale cannot be defined. It is too fluid and perhaps, too significant to be confined within a framework of words. It is much more than a man's chemistry which can be spread out on a small table —a few grains of various metals and salts. Morale is more than man as an amazing engineering mechanism, complete with a filing system which if not abused will function effectively for upwards of 70 years as his stowage and sewage plants. Human morale is more than can be revealed by even the most meticulous scrutiny of his mental functions—his memory or his emotions. Morale is much more than any of these things, since man is much more than the sum of his separate parts.

Great military leaders understood the significance of morale. Napoleon said that only one-fourth of victory depended on men and material; the remainder on the spirit of the soldiers. He knew that while an army marched to the objective on its belly, it took the objective by its morale.

In a democratic nation, morale is trust and faith, not in the numbers of population, the natural resources or the technical achievements, but in the national will and spirit, not only for the present situation but for the future. National morale is expressed as love for one's country; strong desire to live for it, and if needs be, to die for it.

Psychiatrists understand the need for morale in their patients. Unless the patient has the will to get well and return to his former life of reality, then no magic of chemical, electrical or psychological treatment will serve to gain a recovery.

What power is strong enough to be able to threaten and perhaps shatter national morale? It is evil and unscrupulous propaganda. Psychiatrists know enough about propaganda to take it very seriously. It is not a haphazard thing, but an accurate science whose results are predictable. Unscrupulous propaganda is as bold as the brass of Schickelgruber who asserted that the bigger the lie the more successful the propaganda; as devious as the twisted mind of Herr Doctor Goebbels. It has more than 30 techniques at its behest, but it likes best to spread rumor by word of mouth, frequently bought and paid for, although often enough it finds it can penetrate existing movements and organizations and distort them to its own evil purposes. Thus it seeks to alienate labor from capital; to produce dissatisfaction in the men who have been

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PSYCHIATRIC PROBLEMS IN THE WAKE OF THE WAR*

GREGORY ZILBOORG, M.D.

The Author. *Gregory Zilboorg, M.D., of New York. Psychiatrist; Medical Historian; Associate Editor, Centenary Volume, American Psychiatric Association.*

We, mortals, are more keenly aware of the passing of time than we like to admit, and with eagerness and solemnity we seek to attach ourselves to the rapid stream of events so that our always present, albeit unconscious anticipation of our own passing may lose that pang of anxiety which we always feel when alone, unattached to the past, and strangers to the unknown future. We celebrate anniversaries, sesquicentennials, and centenaries; in doing so we become a part of that which has been achieved by others before us, and hope in the same manner to become a part of the future. This is the aspiration of the great and the little people, of the vain and the humble, of the believer and the unbeliever, of the mystic and the materialist, of the follower and the dissenter.

This aspiration is neither a disease nor a meritorious quality of man. It just is; it is man. The clinical psychiatrist may well say that it is an empirical fact, inalienable, fundamental. It is this fact that impressed itself upon the mind of such a scholar and materialist as the American sociologist Lester F. Ward, who once said: "Whatever other forms of immortality may be taught and believed in, the immortality of deeds is not an article of faith, but a demonstrated fact. The real immortality is the immortality of achievement. And after all it is personal immortality. This far it resembles Christian immortality, in that only a few attain it. Only the elect are saved. They only are immortal who have achieved. As in Christianity, too, immortality, which is salvation, may be aspired to by all, nay in some degree, it may be attained by all."[1]

To us of this generation, of the closing decade of the first half of the twentieth century, and particularly to us psychiatrists of this generation, this aspiration toward immortality must seem especially disquieting — not the aspiration itself, but the doubts as to probability of its fulfillment, or of a moderately close or even remote approximation to it under the impact of the present world crisis. With pride and inspiration and yearning we may and can identify ourselves with many great events of our past. We celebrate the anniversaries of the Revolutionary War, the Fourteenth Amendment, the French Revolution, the birth of Copernicus, the publication of Vesalius' *De Fabrica*, the founding of the American Psychiatric Association —or the Centenary of Butler Hospital. We bring the achievements of our past within the frame of reference of our present; we add it all to our present in order to link ourselves to the future. Such a linkage is impossible without that forging intermediary which is the present. Fortunately and unfortunately, this our present, which we call euphemistically the world crisis, is a great catastrophe, which leads many to their deaths and demonstrates more man's ability to die gloriously than to live harmoniously with his fellow men. In the midst of such a catastrophe it is more difficult but also more imperative to think of the future. This future is the only link with our past, and it must be salvaged if the immortality of achievement is not to be desecrated.

"Man is the Measure of All Things"

I have said that this problem is of immeasurable concern to the psychiatrist of today. The psychiatrist has learned, particularly in the course of the past one hundred years, that man and only man is the measure of his achievements and failures, and that it is only through us human beings that the world, its problems, its woes as well as its felicities, reveal themselves, impose themselves, and demand solutions. It is the great Christian ideal of the value of each individual man that psychiatry, more than any other science or branch of medicine, has learned to appreciate on the basis of empirical, clinical, scientific data. The old postulate of the Greek philosopher, Heraclitus, that "Man is the measure of all things," has acquired a particularly poignant meaning in the light of modern psychiatry.

In a practical way this humanitarian ideal of the value and equality of man has been the ideal of medicine as a curative art since time immemorial. But it was left to and is the achievement of modern psychiatry to be able to present the empirical and

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*An address delivered at the Centenary Celebration at Butler Hospital, Providence, R. I., on May 10, 1944.

[1]Lester F. Ward, *Pure Sociology*. (New York, The Macmillan Company, 1914), p. 43.

pragmatic psychological demonstration of this age-long and deep-seated humanitarian ideal. This achievement of psychiatry, by its very nature, is both gratifying and disturbing. It is disturbing because the job of forming a proper linkage between our past, through the holocaust of the present catastrophe, and the near future, must be the concern of psychiatry—since it knows, or should know, so much more about man than the historian, or the economist, or the politician. This does not mean that the psychiatrist is the only one fit to shape the future of the world. On the contrary, the psychiatrist is perhaps less able to shape history than anyone else. He can only treat man, and history cannot be treated; it is shaped through but not by man's whim or individual intent. The task of the psychiatrist, like that of any medical man, is to save the earthly man; the more of this saving is done, the greater the humanitarian contribution to the poor history of mankind, which rightfully boasts of so many achievements but which has not yet learned how to avoid mutual and reciprocal slaughtering of man by man. The task of the psychiatrist is salvaging man for the community and from the misguided institutionalized impulses of the community, such as irrational punitive justice and revengeful attitudes toward those who are called—not without bigoted solemnity—transgressors of the law. The fulfillment of this task is the very substance of the humanized linkage between past and future psychiatry. The present war does not make the psychiatrist's task easier, but it does make it more imperative, more inevitable, more unavoidable.

I do not have in mind now the great number of the mentally ill, the neuroses and psychoses, the appearance of which is inevitable under the impact of shaking hands with death and walking back to life under its taunting shadow. This war will bring in its wake, as it has already, more individuals with compromised personalities, just as it will and does bring physically maimed and deformed. More hospitals will be founded, our present psychiatric skills will be sharpened and enhanced, more and new skills will be developed. Medicine, and psychiatry as a part of it, always thrives when it has more and new work to do, and the ways and means to do this work grow with the amount of the work itself.

From the days of Pinel and the Tukes to the present, psychiatry has grown on and with its problem. A little over fifty years ago, the psychiatrist—whose business was only "insanity"—knew really nothing about neuroses. Charcot became more aware of them than anyone before him, but he still knew not very much. In the course of years we learned to describe neuroses better than our predecessors had, and even to describe them well—as Braid and Janet did, for instance,—but we still did not know much about whence they came and how to treat them. It was not Freud who discovered the nature of the neuroses, but it was the neuroses that brought about Freud. As the number of neuroses became greater and our psychological eyes less astigmatic, we not only learned to discover them but we developed a variety of efficacious techniques to deepen our understanding of them and to enhance our therapeutic influence. As a result we have numerous child guidance and psychiatric out-patient clinics which deal primarily with neuroses—organizations not heard of some twenty-five years ago.

In other words, psychiatry found the medico-psychological means to deal with the problem as it imposed itself upon us; and its words carried enough conviction to impress the community and force it to respond with a considerable degree of cooperation. Not enough cooperation, to be sure—but this cooperation will never be sufficient, since the therapeutic appetite of medicine is always greater than the conservative dispensations of the community. Psychiatry is always ahead of the community; this is perhaps the reason why the community always treats psychiatry with some derision and much skepticism and self-injurious caution. Psychiatry has always been and still seems to be in the position of a radical who wants a great deal from the community *for* the community, and whom the community — depending upon circumstances—treats as a dangerous interloper or a mere "crack-pot."

However it may be, as neuroses asserted themselves clinically in our civilization, psychiatry devised the means to meet the problems they represented. Today a great many psychiatrists know more about neuroses than about their eminent domain—the psychoses. From the scientific point of view it is a regrettable fact that the psychiatrist tends to neglect the knowledge of psychoses. But from the standpoint of historical necessity it is an instructive and perhaps even welcome fact. The last and particularly this war find psychiatry in the forefront, and the point of greatest concentration of our psychiatric concern and therapeutic endeavor is the neuroses.

We may therefore expect with confidence that the purely clinical and administrative psychiatric problems which this war will leave in its wake will be duly met by psychiatry. These problems probably will not be the most difficult which our specialty will be called upon to face.

There are other problems, less obvious although already conspicuous, which psychiatry may well approach with some anxiety—with less confidence, at any rate. To appreciate these problems we must turn our attention for a moment to a region which at first glance lies beyond the purely clinical field.

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THE WAR AGAINST FEAR AND HATE*

KARL A. MENNINGER, M.D.

The Author. *Karl A. Menninger, M.D., of Topeka, Kansas. Chief of Staff, The Menninger Clinic.*

WHILE the greatest war in history is in progress, we are met together to celebrate the founding of a psychiatric hospital marking an epoch in what is really a much greater war, a much longer war, a war that has been going on for centuries.

In the early 1820's an undistinguished but energetic young woman by the name of Dorothea Dix established a private school in Boston. At that time the regular grammar schools of Boston were "dens of cruelty kept by tyrannical men who were proud of their different switches, rattans and rawhides, and regarded them," said Edward Everett Hale, "as the only real instruments of education." Perceiving that need, Dorothea Dix established her school along different principles.

After fifteen years of it, when she was 34, she suffered an illness, gave up her school and went to England. Here she probably met Dr. Samuel Tuke, the son of William Tuke, the Pinel of England, whose work of fifty years previously had gone without influence upon the people of the hospitals of the United States.

On a raw March Sunday in 1841, five years after the onset of her illness, the recovered Dorothea Dix visited the East Cambridge jail in Boston to teach a Sunday School class. Among the prisoners were some mentally ill persons. All were being treated with an equal degree of barbarous cruelty and neglect.

The perception by Miss Dix of the suffering of these unknown prisoners and patients in the East Cambridge jail led to a declaration of war against fear and hate and human cruelty that culminated in the present day institutional psychiatry of America, of which we now have reason, I believe, to be proud.

In the course of her investigations of existing conditions, Dorothea Dix came to Rhode Island in the spring and summer of 1843. There were at that time no provisions in this state for the care of the mentally ill, public or private. "Justices of the Peace continued to commit to the county jails according to law, 'furiously mad persons dangerous to the peace and safety of the good people . . . ' Less violent persons were confined at home, boarded out, or provided for in the local almshouse."

It was in Rhode Island that the celebrated case of Abraham Simmons was discovered. He was a psychotic patient confined in a stone-roofed, stone-floored cell, tethered to the stone floor by an ox-chain: " 'Sometimes he screams dreadfully and that is the reason we had the double walls and the two doors,' explained the woman who had conducted Miss Dix to Simmons' cell. 'His cries disturb us in the house. . . . My husband sometimes of a morning rakes out half a bushel of frost, *and yet he never freezes!*'

" 'How long has he been here?' inquired Miss Dix, according to her biographer, Helen Marshall.*

" 'Oh, about three years,' was the answer."

Simmons was by no means an unusual case but for some reason or other the inhuman conditions of his confinement made a particularly deep impression upon Miss Dix and upon responsible citizens of Rhode Island to whose attention she called them. Among these was Nicholas Brown, who had bequeathed $30,000 to be used toward the erection or endowment of a retreat as had been provided by an act of legislature. Brown died in 1843 and the Rhode Island General Assembly issued a charter for such a retreat in January, 1844. The same year Cyrus Butler gave $40,000 on condition that an equal sum be subscribed.

Miss Dix prepared an article . . . for the *Providence Journal,* and then went to Newport where the legislature was sitting. When members of the legislature called to talk with her about the proposed hospital, she pressed the Simmons case and told them how the town had promised ten months before to move him to a hospital but had taken no further action. She had come to Newport, she said, to secure his removal; she could not take him away without the consent of the town but the legislature might intervene.

"Mr. Updike, one of the legislators, was greatly moved and declared that the assembly should inter-

*An address delivered at the Centenary Celebration at Butler Hospital, Providence, R. I., on May 10, 1944.

*Marshall, Helen E.: *Dorothea Dix. Forgotten Samaritan.* Chapel Hill, University of North Carolina Press, 1937. This is the source of the data here given regarding Miss Dix.

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pose at once. He went to the house of representatives and made a speech that roused everyone. A member from Little Compton then arose and announced the death of Simmons. There was an awkward pause — mercy had come too late. Finally another member arose. There were other insane paupers in Rhode Island; he moved that a committee be appointed to investigate their condition. The motion carried . . .

"Miss Dix's next visit to Rhode Island saw the hospital fund oversubscribed."

The Great War of Our Times

You know the rest. These grounds were then selected, these buildings planned, these walls constructed, these rooms equipped. A competent staff was enlisted. Miss Dix had won a battle, and she had just begun. The war was to go on against fear and hate and prejudice and bigotry and selfishness and meanness and the dangerous lusts. By lusts I do not mean the yearnings associated with sex, which civilization has whipped and shackled into comparative innocuousness; I mean the lust for power, the lust for accumulation, and the lust for cruelty. It is these lusts which make men sick and which bring suffering and sorrow and disability. It is the war against them that constitutes the great war of our times, if we could only know it, not the bloody conflict of flesh and metal that our daily papers record in the headlines each morning. The war I am thinking of is fought by guerrillas and underground patriots, in unspectacular actions, in secluded places—like this. Like the war abroad, this silent war at home has its tragedies, its screams, its bloodshed and its sorrow. But instead of great daily headlines for all to see, there are only occasional modest reports in stodgy medical journals; instead of thousands of tons of explosives, there are only many quiet hours of counsel and comfort; instead of campaigns of destruction, there are campaigns of planned rehabilitation; instead of billions of tax money, there are only a few thousand from private and state benevolence.

Right here where we stand and sit, within these walls, hour upon hour, day after day, the battles of this war have been fought, and are being fought. Commanded by a wise, far visioned general,* who sits beside me here on the rostrum, and by his illustrious predecessors** listed on your programs, company after company of soldiers have taken their posts. Volunteers, replacements, technicians, executives, Grey Ladies, White Ladies—they are all here—just as in that other army. Spurred by their example of devotion, service, and scientific idealism, other companies have been organized, and new battalions formed in units reaching now from Providence in the Northeast to San Diego in the Southwest and from Seattle to the Keys. But the name of Butler Hospital, one of the first fighting units in the great war against fear and hate, remains in the front ranks.

If I have seemed to carry this figure of speech too far, I would like to speak directly to the point of proving that it is not a metaphor or simile, but a truth, a statement of fact. For after all, what is it that we do, we psychiatrists and our aides, in the cooperative group attack on mental illness represented by the modern psychiatric hospital? It is no longer—as in the times of Dorothea Dix — a matter of providing humane and decent living quarters, food and asylum from the curious and often cruel world, for a few hundred or a few thousand sufferers. All that is taken for granted today, thanks to Miss Dix, Clifford Beers and others. In those days that was about all that one *could* do for the victims of these mysterious afflictions of the spirit. "What is it to be mad, but to be simply mad?" expressed what was then the universal consensus.

Today we know that to be mad is not simply to be mad. It may be to be overwhelmed with toxins, or to be invaded by micro-organisms or to be subject to adventitious growths or perversions of glandular tissue. Or it may be to rebel against the injustices and inequalities of fate, or against the dishonesty and hostility of fellow workers or against the mistaken zeal or prejudice or misunderstanding of friends and family. Whatever its origin, madness can be and must be combated, and often it is best combated by the joint efforts of psychiatrists, nurses, physicians, therapists, and others that make a HOSPITAL.

Our conceptions of the nature of mental illness have run the gamut from the "brain-spot" hypothesis to the "mind-twist" hypothesis* and back again; today we are inclined to discard both in favor of conception that mind and brain and body and soul are inseparable, that disease is not the affliction of an organ alone, and mental disease not an affection of the brain alone, but that the total organism, the individual as a whole is integrated with a physical and social environment and can only be so considered, either in sickness or in health.

Thus *adjustment* becomes the keynote word of modern psychiatry, and failures in adjustment its chief province. This does not require that we discard what we have so painfully acquired in regard to anatomy and bacteriology and immunity and pathology and arsphenamine and penicillin and hydrotherapy and psychoanalysis. On the contrary, it requires that we use all this knowledge, all these approaches, all these methods—and at the same

*Dr. Arthur H. Ruggles.

**Dr. Isaac Ray, Dr. G. Alder Blumer and others.

*Terms suggested by Ernest E. Southard.

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THE FUTURE OF THE VOLUNTARY HOSPITAL*

ALAN GREGG, M.D.

The Author. *Alan Gregg, M.D., of New York City. Director, Division of Medical Sciences, Rockefeller Foundation.*

THE invitation to speak to you this evening on the future of the voluntary hospital has called for an effort which is more than compensated by the pleasure of being your guest and by the satisfaction of being a witness of your work. No institution for the care of mental ills can be maintained for a hundred years of uninterrupted service without deserving more heartfelt praise than could ever find utterance in any eulogy, nor could any structure on these grounds contain all the persons to whom such gratitude should be uttered. There are thousands living and tens of thousands no longer alive whose hands and hearts have contributed to the steadfast success of this hospital. Before the unreckoned total of so much work, so much care, so much loyalty to the ideal of charity we might well bow our heads in solemn gratitude and humble pride.

Since justice could hardly be rendered to the accomplishment you celebrate today, and since my assignment by its very title looks to the future of an institution rather than to the imposing record of its past and present supporters I shall turn to a subject of general yet immediate concern: the future of the voluntary hospital. At the very outset I shall assume that you have such familiarity and experience with the nature and function of at least one voluntary hospital as is suggested by your several and variant offices in this hospital and your interest in it. No time need be spent in belaboring you with facts you already know. Rather than do that I shall venture to offer you a new way to think about the hospital as an institution—a way which may cast some light upon its future.

If at first this way of thinking seems somewhat abstract or expressed in terms apparently intangible and vague, have patience and do not prejudge the structure of the idea until my necessary scaffolding can be removed. I shall first describe a way of thinking and then I shall apply it to the future of the voluntary hospital.

*An address delivered at the Centenary Celebration at Butler Hospital, Providence, R. I., on May 10, 1944.

My thesis is this: in thinking about any organization or organism we pass through three stages of understanding—first we grasp its form, second we come to understand its function, and finally we comprehend its relationships to everything else. If we may expand this statement we could say first we study something in terms of its form, composition, arrangement of parts. When those are familiar we are ready to study its function, how it works, what it does. And lastly with such form and function what relationships does it have to the rest of living, what values does it possess, what meaning or significance does it hold? Let me offer examples of these three aspects of knowledge.

In medicine the student begins with anatomy, the structure, composition and arrangement of the body. Then he comes to physiology, the functions of the living body; functions both normal and impaired, for the knowledge of disease comes best in terms of the impairment of function. Lastly the student, when he is well taught, is led to study the relationships a human being must bear to his fellows, to the external physical world, and to the world within. If it be not too large a digression let me observe in passing that psychiatry deals especially with just such relationships—the relations a human being has with other human beings, the world of reality and of the spirit.

Or let us consider this tripartite formula of form, function and meaning, as applied to the study of the automobile. We begin with the design, the arrangement, the composition of its parts. Wider understanding comes when we see how they work: indeed delight and mastery reward anyone who knows how an automobile runs—and what is needed to make it run. But the fullest knowledge of the subject comes to him who also comprehends the impact of the automobile on modern life—on social intercourse, on the practice of medicine, on rural life, on interstate commerce, on the administration of justice, on vacation spots, on other forms of travel such as the horse, on mechanized warfare, etc.

One more example: the art of printing. Almost exactly five hundred years have passed since Gutenburg produced the first printing in Western Europe. Compared with the previous methods of producing written language it was a tremendous

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invention. Functionally its significance lay in providing exactly similar copies in great numbers at very low cost. And if we think of the relationships of this invention to the rest of living, i.e. the value meaning and significance of printing we can experience the emotion of wonder in almost pure form in the face of all that printing has meant to the spread and to the storage of fact and opinion and the imaginings of man. It has reached millions and over centuries of time. New forms of human association and government have been made possible by printing: it has furnished an incalculable aid to education and enlightenment.

Now this formula for thinking about organisms, machines, inventions or organizations in terms of form, function and outside relationships you can use tomorrow on any of your own affairs, organizations, or machines, and if you do so with any thoroughness I predict that you will arrive at some interesting conclusions.

In the first place you would conclude that as a rule most people devote more attention to form and function than to value, significance or relationships. For a hundred men who know what a carburetor is and what it does, only one knows that the automobile, in eliminating stables in large cities and thus the infinite profusion of flies in the houses of the poor, has greatly reduced the urban infant mortality due to infections spread by flies. Though knowledge of form and function is essential, comprehension of outside relationships is rare and deserving of more study than it receives.

Next, if you use this way of thinking about things, you will find that you cannot change the form without having a resulting change of function and somewhere a change in relationships and significance. Indeed no one of the three can change or be changed without corresponding and resultant change in the other two. This is a singularly important fact. It explains why institutions must change to meet changes in their environment—their outside relations—if they are to keep significant. It explains why new buildings or new forms of organization work in new ways and acquire new significances.

And lastly you will see that any organization or organism is always exposed to threats and competition from new forms, new functions or new values coming from other quarters than itself. Streptococcus infection threatens certain tissues of the body. Flying at 35,000 feet, or taking on a great deal of alcohol impairs certain functions of the nervous system. Passionate devotion to irrational standards of self-esteem destroys satisfactory social relationships. Structural changes in machines change their performance potentials, and fast driving implies a change in the social status of the drivers in the eyes of the law as well as verifiable changes in the anatomy of the car.

Form, Function, and Meaning of Voluntary Hospital

I think we may now turn our formula to account in the task of examining the future of an institution —the voluntary hospital.

In form the voluntary hospital as we have known it in America during the past hundred years has shown these characteristics: it was initiated by individuals and supported by private donations of time and money and its policy and programs of work were determined by private citizens in collaborative effort for the public welfare. Frequently, but not always, the interest derived from a church or group of churches. Usually the support came from local or at most regional sources. Virtually without exception the management of the hospital was free from political control and usually independent of any income derived from taxation.

In function the voluntary hospital has furnished the best example of leadership in medical care and exemplary administration in the development of the American hospitals. Though cases could be cited of voluntary hospitals being narrowly denominational in point of their management I have never heard of any sectarian or religious lines being drawn to the exclusion of patients on the basis of religious faith. And on the whole it is probably accurate to say that the trend is away from narrow denominational control even in voluntary hospitals whose name and histories record denominational origins. The growth of hospital management reflects the intelligent practical interest of businessmen on the boards of trustees even more than the increasing piety of subscribers and supporters. If any unfavorable criticism can sensibly be made of the functions of the voluntary hospital today it would be that each voluntary hospital considers itself a law unto itself and in no way bound to collaborate with other agencies for medical care whether private or public. Such deliberate disregard of the environment produces isolated and rueful absurdities at times, and impatience even in the persons of a judicial temperament.

If then the form of the voluntary hospital has exemplified cooperating benevolence independent of government and political control, and the function has been that of providing leadership and quality, what may be said of the meaning and value of the voluntary hospital?

The voluntary hospital, more than any other place where medical care has been given, has set the standards for medical practice of every kind. The voluntary hospital has contributed to the advancement of clinical medicine. It has taught the physician, by nature none too tolerant of criticism

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The RHODE ISLAND MEDICAL JOURNAL

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BUTLER HOSPITAL

IN January, 1844, a charter was granted by the General Assembly to the Rhode Island Asylum for the Insane. On November 8, 1844, the corporators, a group of earnest, public-spirited men, met in the Providence City Council Chamber and passed a resolution offered by Professor Goddard and seconded by President Wayland, of Brown University, that "hereafter said Corporation shall be known and called by the name of the 'Butler Hospital for the Insane.'" Thus was opened the first chapter in the history of Butler Hospital, the first in the State, which recently celebrated the centenary of its foundation and to which the editors have the honor of dedicating this issue of the Rhode Island Medical Journal.

Nicholas Brown and Cyrus Butler, wealthy merchants of Providence, men as clear of brain as they were warm of heart, by their munificence, made possible the building of the hospital. Mr. Nicholas Brown had made a codicil to his will directing his executors to pay the sum of $30,000 towards the establishment of a hospital "where that unlucky portion of our fellow-beings, who are by the visitation of Providence deprived of their reason, may find a safe retreat and be provided with whatever may be conducive to their comfort and to their restoration to a sound state of mind", provided it was founded "on a firm and permanent basis."

At about the same time, Mr. Cyrus Butler, whose feelings were enlisted in the movement, determined to further the establishment of such an institution, provided it could be carried out according to the enlarged and correct views of his late friend, Mr. Nicholas Brown, and on a plan suited to the wants of the State and equal, at all events, to any in the country. For this purpose, he offered to donate $40,000, provided the executors of Nicholas Brown agreed to pay the bequest of $30,000 and that the further sum of $40,000 was raised from other sources, making a total of $110,000. It is important to relate these facts, because they render untenable two myths concerning the foundation of Butler Hospital.

One myth has it that the famous humanitarian, Dorothea Lynde Dix, bearded the close-fisted Cyrus Butler in his parlor and persuaded him to give $40,000 "toward the enlargement of the insane hospital in this city." The other myth perpetuates the impression that Butler Hospital was founded by rich men only. Both of these myths are without any foundation in fact and it is not the least of Mr. William G. Roelker's recent services to true history that he has disposed of them completely.

The philanthropy and the natural generosity of Cyrus Butler required no persuading; and the available records show that not rich men only, but also several hundred poor men — a gardener, a grocer, a machinist, a none-too-well-paid college

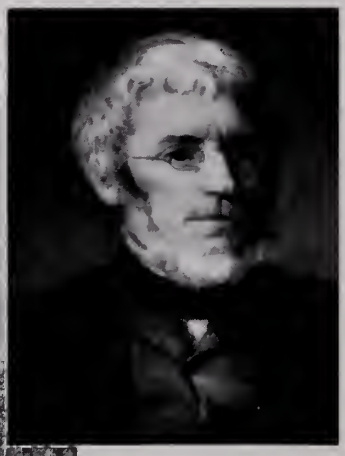
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A CENTURY OF PROGRESS

Rhode Island's First Hospital . . . Butler Hospital, 1844-1944

THE ORIGINAL BUILDINGS — *From an old engraving*





ISAAC RAY, M.D.
First Superintendent



THE HOSPITAL TODAY

ARTHUR H. RUGGLES, M.D.
The sixth and present Superintendent



professor, a jeweler, a barber and many others of modest means contributed small amounts of money to the subscription list of the proposed hospital. And so, at its birth, one hundred years ago, as even today in its serene maturity, Butler Hospital enjoyed the good-will of the whole community.

If one were to describe in a sentence the abiding spirit and savor of this true *hospitium*—this guesthouse for the mentally ill, he could find none more suited to his purpose than that which is inscribed on the seal of the hospital, *MISERIS SUCCURRERE DISCE*. How effectively Butler Hospital has learned to succor the unfortunate, her grateful patients have testified gladly these hundred years. And, perhaps, it may be of interest to record that among the most loyal friends of the hospital are many who were patients there.

As William Osler fashioned the Johns Hopkins Hospital after his own image, so did Dr. Isaac Ray bequeath to Butler Hospital the principles and the practice of his enlightened medical philosophy. Dr. Ray was a remarkable man who for twenty-two years served as its first Superintendent and during this formative period created the psychiatric tradition which has characterized the hospital during its hundred years of service. For him psychiatry was never divorced from general medicine; he never made the mistake of bifurcating the living patient into a mind and a body, for as a realist he saw the essential unity of human personality and long ago, by his avoidance of the Cartesian dualism he thoroughly understood and practiced what today we call psycho-somatic medicine. He was an authority on medical jurisprudence; he wrote on mental hygiene before Clifford Beers was born; he taught the value and the necessity of psychological analysis; he was an enthusiastic protagonist of occupational therapy; he appreciated the importance of games, music, reading, and nature studies in the treatment of his patients and in general insisted upon the need of what he termed "moral management" in the therapy of the mentally ill. "The kind of moral management on which I have relied," he wrote, "is that now adopted in all modern hospitals for the insane. It consists in the regularity of the service, in the exclusion of whatever is calculated to annoy or excite, in skillful dealing with delusions and caprices, in the employment of the mind in work or recreation or reading, and in the exercise of kindness and forbearance on the part of all engaged in the service of the establishment. In other words, it consists essentially in placing the patient in a position where, with the greatest amount of favoring circumstances, and the least amount of let or hindrance, nature may be left to do her kindly work." Surely no one could conceive a more comprehensive psychiatric program than this; and from Dr. Ray to Dr. Ruggles it has motivated the activities of Butler Hospital.

Inspired by the spirit of charity, favored by the devoted services of successive Boards of Trustees, and equally favored by the broadly-based experience of her Superintendents and their associates, Butler Hospital has become a friendly family group wherein the ill have been succored by the well and the well have been rewarded with those satisfactions which derive from the performance of labor in the furtherance of a noble and ennobling cause. And if the past is an earnest of the future, then, indeed, the people of Rhode Island may rest assured that Butler Hospital will continue to render the splendid service made possible by Nicholas Brown and Cyrus Butler who ardently desired and hoped that, as Cyrus Butler expressed it, this new institution should be carried forward "on a plan suited to the wants of this State and equal at all events, to any in the country."

FOR OUTSTANDING COMMUNITY SERVICE

Arthur Hiler Ruggles has been among the foremost in pushing back the frontier of healing to include the once unknown territory of the human mind. In the last war he led the way in psychiatry with and for the soldiers at the front. So again today he is alert and resourceful in the face of history's most violent assault upon man's inner strength and peace.

In this, his 25th year as superintendent of Butler Hospital, he continues to keep the institution responsive to great opportunity. He has taught the layman that a mind unwell is no more shameful than an ailing body. He has fought for public appreciation of a ministry that must be private and has shown that there can be sympathy as well as skill in its direction.

Most of Dr. Ruggles' rewards must come in those quiet satisfactions which attend a physician's victory in bringing hope and consolation and return of health. But this accolade shall be in the light of day and in the fullness of our hearts.

Text of Citation Presented with Second "Roger" Award of The Providence Journal Company July 9, 1944

TUFTS DENTAL SCHOOL

Probably no dental college in the country has greater influence on a region than has the Tufts Dental School. For many years it has been the principal source of New England dentists and its training of them has been especially adapted to the particular problems of the northeast states.

With dental education moving forward to new high levels, and with new rulings by the American Dental Association and the various dental licensing boards of the states calling for obligatory hospital training, Tufts Dental School now turns to its

continued on next page

alumni for justified support of its plans for expansion and improvement. The immediate need is a new building to replace the fifty-year old structure whose usefulness does not encompass the facilities for the new demands on dentistry. Possession of a modern facility will also allow the development of refresher programs and post graduate courses for the alumni to an extent hitherto impossible.

A fund of $300,000 is being raised to construct and endow a medical-dental building on a site adjacent to the New England Medical Center in order that new programs for efficient and effective training of dentists may be augmented through contractual relations with the hospitals. With the College unable to divert any of its funds, which are restricted to particular purposes, the appeal goes out at this time to all friends of dentistry, whether Tufts alumni or not, to contribute to this progess in dental education in New England which will directly aid the entire profession of this region.

PUBLIC POLL ON SURGICAL INSURANCE

This month the Rhode Island Medical Society makes a new progressive approach to the much discussed question of the distribution of the costs of medical care with a statewide poll that is undoubtedly unique in the history of American medicine. Departing from the procedure adopted in other sections of the country whereby plans have been developed and insurance contracts offered without definite evidence of a public demand, the Rhode Island Medical Society, through its Committee on Medical Economics, is placing the matter to the public directly, and on the basis of this referendum it will formulate future programs.

No mere sampling of the population will be attempted. On the contrary the Society will print and distribute, in cooperation with the Hospital Service Corporation of the State, approximately one hundred thousand questionnaire cards, thereby reaching approximately one-fourth of the entire population of Rhode Island. While some of the distribution will be by mail, the bulk of it will be done by the Blue Cross at the time it issues its Special News Bulletin to its membership in the established employments throughout the State.

Logically approaching the question of the expense of surgical operations as a major problem for all persons, the Society seeks in this initial poll to determine the interest in a voluntary surgical insurance plan under medical society supervision. Later, additional polls will be attempted to cover the entire question of the cost of medical care in the hospital, as well as in the doctor's office and the home.

While no attempt is made to establish premium rates should a surgical plan prove desirable, the poll indicates the possibility of rates comparable to those of the Blue Cross for hospitalization, and, as with the Blue Cross, the benefits will be applied towards the total cost and will not necessarily encompass it.

The success of this study is a matter of conjecture. Certainly it is a realistic approach to a question that has created wide discussion and relatively little research. In taking the matter to the individual citizen for his opinion and advice the medical profession demonstrates anew its desire to do all in its power to assist in the distribution of the costs of unpredictable illnesses. If the public cooperates the Society should accumulate valuable statistics to guide it in sound planning for the Future.

BROWN AND MEDICAL EDUCATION

The action of Brown University in establishing a Department of Medical Sciences, described in the statement of Vice-President Adams which is published in this issue, represents a significant contribution to the renaissance in medical education which must develop in the early post-war period. Besides being a part of this great movement which must take place on a national scale, it will be a potent factor in filling a need in Rhode Island in particular, a need which has existed for many years of which the medical profession has been fully cognizant.

The high standards for acceptable hospitals, residencies and internships which have been established by the Council on Medical Education and Hospitals of the American Medical Association and the work of the examining boards for certification of specialists, have greatly aided in assuring to the public that the experts on whom they must rely for diagnosis and treatment are really experts. Such experts must be trained. In the hospitals of Rhode Island a wealth of clinical material is to be found, comparable with that in many of the best known medical centers in the world. What has been lacking has been adequate organization and facilities for instruction. The establishment of residencies, fellowships and other educational opportunities has been possible only to a very limited degree in the past because of this lack of organization and supervision as well as of facilities for work in the basic sciences underlying each special field. Now, with the establishment of the new department at Brown it is to be hoped that such organization and supervision will be provided. This will create opportunities for physicians, especially those returning from duty with the armed forces, to do the advanced work necessary in fulfilling the requirements of the specialty boards, thus qualifying themselves for practice as specialists. Furthermore this department should become a factor in aiding any physician to improve his training whether his practice be specialized or general. The Rhode Island Med-

ical Society is already in the process of exploring means to raise the level of education and therefore of practice throughout the state and this forward step taken by our oldest University should be a potent factor in bringing success to these endeavors.

DOCTORS IN POLITICS

The term public servant has long been embraced by politicians as a title befitting their office, however well or ill they might fulfill their public duties. The doctor, outstanding in every community and always foremost in matters of public service, has strangely remained outside the pale of this title politically. For some reason never clearly explained he has avoided the spirited arena wherein the public is always an ailing patient, the prescription is always a new plank of promises, and the payment for diagnosis is made in votes.

With leadership vital to every endeavor, and at a time when the professions need stronger representation in the political life of our country, it is significant that Dr. Angelo M. Parente, an outstanding member of the Rhode Island State Dental Society, has accepted the call to enter the competition for the office of Mayor of the City of Providence. A native of this city, Dr. Parente has practiced his profession here since his graduation from Tufts College Dental School in 1921. He has served as a member of the State Board of Dental Examiners, and he holds membership in the American Dental Association in addition to his state society affiliation. His community service includes four years as a member of the Providence City Council, and two years as a member of the Board of Aldermen.

As a doctor and as a citizen Dr. Parente has contributed much to the civic improvement of his community. That he has been selected by his political party to carry its standard for the important post of Mayor is eloquent tribute of his ability. We express the hope that his willingness to sacrifice time from his professional work may inspire others of the medical and dental fraternity to seek public office in the years ahead.



ANGELO M. PARENTE, D.M.D.
Republican Nominee for Mayor of the City of Providence

DEPARTMENT OF MEDICAL SCIENCES AT BROWN

Statement from DR. JAMES P. ADAMS,
Vice President of Brown University

As we approach the climax of our military effort in the war and contemplate the continuing efforts by which it will be brought to a conclusion we are all looking forward to the responsibilities which we must face in the days of transition from a war to a peacetime economy. This is particularly true of institutions which have not only a responsibility to themselves, but also, in a more significant sense, an obligation to serve the larger social purposes which brought them into existence.

As in the case of other educational institutions, Brown University is planning for this future and is attempting to define its responsibilities and envision its opportunities in the changed settings of the post war years.

Among the actions which have recently been taken by Brown University as a part of these plans is the establishment of a *Department of Medical Sciences*. Because of its location in a metropolitan community, because of existing relationships with other institutions, and because of its own personnel resources and its library and laboratory facilities, the University can make significant contributions in this field and, by the establishment of this Department, has indicated its purpose to do so.

This new department will perform certain important functions within the University itself — functions related to the health education of its students and to the orientation of students planning to pursue professional study in the art and science of Medicine.

Through this department, the University will also offer opportunities for advanced study and research to members of the medical profession — in fields of special interest in which the University is prepared to furnish professional direction and teaching and research facilities. This is designed in part to meet the needs and desires of recent graduates of medical schools whose post-graduate studies in certain specialized fields of medical science have been interrupted by war service. But beyond this matter of more immediate interest, it is designed to provide opportunities for the pursuit of special scientific interests to other members of the medical profession who reside in this community. In this connection, one of its most fruitful contributions may result from collaboration in the development and conduct of educational programs planned and being planned by hospitals as a part of their own responsibility for effective service to the community and to the members of the medical profession through whom they carry on their work.

The establishment of the Department of Medical Sciences by Brown University is a confirmation of the University's desire to continue and enlarge its service in this field.

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RHODE ISLAND STATE DENTAL SOCIETY

DENTISTRY AT BUTLER HOSPITAL

HAROLD SUTTON, D.D.S.

Member, Board of Consultants, Butler Hospital, Providence, R. I.

IN marking the centennial of Butler Hospital's foundation, the dental profession in Rhode Island would like to call attention to the part that it has played in the care and treatment of patients in this century old institution. To those who remember the rather primitive equipment of dentistry in the early days of Butler Hospital, which was established in 1844 just a short time after the first dental school, it is often forgotten that dentistry had its beginnings even centuries before that.

St. Appononia, the patron saint of dentistry, who suffered the removal of her teeth and parts of the jaw bone because she persisted in missionary work against the displeasure of the king, was one of the first patients on record. Early records in Rhode Island show that two surgeons, Gaudette and Lemaire, members of Rochambeau's Army encamped in Middletown and on the heights near the corner of Rochambeau Avenue and Hope Street—only a stone's throw from Butler Hospital—taught Josiah Flagg dentistry. It is therefore no stretch of the imagination to conclude that right here in Rhode Island was the first dental school, for it was Flagg who went to Philadelphia and trained other men to practice dentistry. Rhode Island was the first State in the Union to adopt a resolution condemning the practice of commercialism in dental education, instead advocating its placement under the control of universities with university ideals and direction.

During the first few decades of Butler Hospital's existence probably the dentist of that era made calls to the Hospital and perhaps had some patients sent to his office. As late as the early 90's local dentists made frequent calls to the Hospital to relieve emergencies and perform such operations as were possible.

Dental equipment consisting of a portable headrest, instruments and dental engine were carried by the dentist from his office. The headrest was easily attached to a chair of the Windsor type. The foot engine, consisting of a tread and flywheel, was not unlike that of a sewing machine. A cord belt transmitted the power from the flywheel to a flexible cable attached to a hand piece. The instruments were carried in a student's case — a wooden box fitted with three shallow trays for the hand instruments, and compartments for the bottles containing drugs. In the bottom of the box was a space for supplies and a receptacle for burs to be used in the hand piece of the engine.

In 1922, when Dr. Arthur H. Ruggles assumed the superintendency of Butler Hospital, dental hygiene was more definitely organized and developed, and a great deal of attention was given to the restoration of carious teeth, the removal of diseased and impacted teeth and the installation of proper dentures. Great improvements were made in the dental clinic. I was appointed to the staff as Consulting Dentist and am performing regular service at the Hospital at the present time.

In 1939 a very desirable location giving maximum light on the top floor of Centre House was selected and a new and up-to-date clinic installed with all the latest equipment, consisting of an operating room, laboratory and x-ray laboratory. Butler Hospital today maintains as well equipped a dental clinic as is to be found in any comparable institution in the country.

A D A MEETING TRANSFERRED

The Board of Trustees of the American Dental Association announces that the 1944 Annual Meeting will be held at the STEVENS HOTEL, CHICAGO, October 16, 17 and 18, rather than in Omaha as originally planned. The dates are a week later than previously announced.

According to Dr. H. B. Pinney, Secretary, the action was taken only after an exhaustive investigation revealed the seriousness of the travel problem and the strong probability that it will be seriously worse by October. It was felt that Chicago offered the best transportation facilities in the country.

"We deeply regret the necessity for this action," said Doctor Pinney, "because of the immense amount of painstaking preparatory work already done by the Omaha Local Arrangements Committee, and particularly by its Chairman, Dr. Herbert E. King. We owe them an enormous debt of gratitude. However the situation with respect to pullman accomodations is so fraught with uncertainty that, in the interest of the Association as a whole, the Board felt compelled to make the move." Doctor Pinney concluded, "Those who already have Omaha hotel reservations should cancel them and make new reservations in Chicago."

ADVANCE ANNOUNCEMENT TO DOCTORS

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In Response to Recommendations of Many Rhode Island Physicians, Blue Cross Now Extends Protection to Self-employed, Unemployed, Retired, as well as Persons Employed in Establishments Having Less Than Five Employees. This Individual Enrollment Period is Open From August 27th to October 18th Only.

Although more than 200,000 Rhode Islanders are now enrolled in Blue Cross through group membership, other thousands of individuals have not been eligible. Now, the new widespread service of Blue Cross is open to these persons for this limited period only. This opportunity will appeal to domestics, farmers, fishermen, professional persons, small business men etc.

The age limit is 65 years and the usual Blue Cross health statement is required. The waiting period for maternity cases will remain at 9 months.



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PROVIDENCE, RHODE ISLAND

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THE CONTRIBUTION OF PSYCHIATRIC NURSING TO NURSING EDUCATION*

ELIZABETH S. BIXLER, M.A., B.N.

The Author. *Elizabeth S. Bixler, M.A., B.N., of New Haven, Conn. Dean, Yale University School of Nursing.*

EVENTS are moving so rapidly today, the present slips by so quickly, that we are all living rather breathlessly in the future. Nevertheless it is sometimes helpful to turn to the past in order to determine what should or should not be carried over into present practices and future plans. The meagre historical data available on psychiatric nursing show two things rather clearly—first, that in the past psychiatry and psychiatric nursing were considered quite apart from general medicine and nursing and secondly that, except for the darker periods of history, psychiatric patients have received care and supervision from persons who may by courtesy be termed psychiatric nurses and who utilized, either through precept or through intuition, some of the principles of psychiatric nursing which today are considered basic. It is impossible to divorce the ancient history of psychiatric nursing from that of psychiatry. There have always been mentally sick persons. Sometimes they received no care at all; at other times they evidently received care commensurate with the scientific knowledge of the period, whether the "doctors" were medicine men, high priests, or learned scholars.

For illustration, a few individuals may be cited who cared for psychiatric patients with considerable discernment. One of the earliest written reports of one who may be considered a forerunner of psychiatric nursing concerns a man, Joan-Baptiste Pussin, who, although without the benefits of a psychiatric nursing education, was a close and trusted associate of Pinel in his great reformation of psychiatric practice and of whom Pinel himself has written in terms of affection and esteem. In 1785 Pussin was employed as supervisor at Bicetre and according to the record it was he who first experimented in removing restraints from some of the patents. Pinel has acknowledged that Pussin, because of his commonsense understanding of his patients, his devotion to his work and his sense of justice, was of great assistance to him, both at Bicêtre and later at Salpétrière. In addition to these qualities Pussin had sympathy, gentleness and good humor all of which today are considered essential for the psychiatric nurse.

Closely associated with the work of Pinel was that of Samuel Tuke in England. When the York Retreat was first opened with 15 patients the staff consisted of a superintendent, a housekeeper, and two men and three women servants. There is no doubt that these "attendants" were taught the proper care of psychiatric patients by Samuel Tuke and other doctors. Even at that time the personality of the attendant was considered important. They were urged not to be familar with the patients, yet to do everything possible to arouse their confidence. The attendants were not to reason with the patients, nor to be condescending. In the words of the great Quaker leader "to applaud all they (the patients) do right; and pity, without censuring, whatever they do wrong, requires such a habit of philosophical charity as is certainly difficult to attain." In modern terminology psychiatric nursing teaches that the *attitudes* of the nurse, varying with the psychological needs of her patients, are of paramount importance.

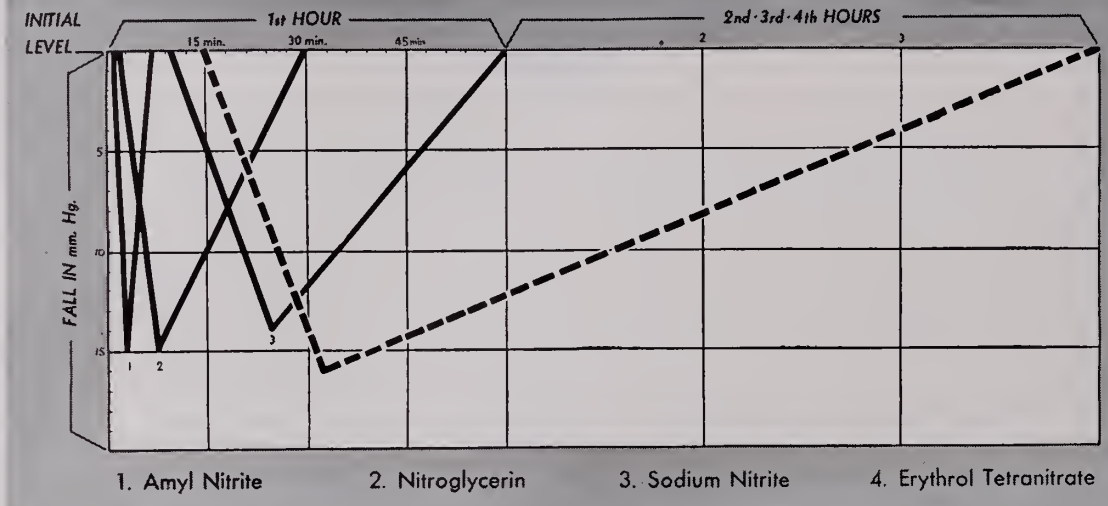
Expansion of Nursing Care

The first psychiatric nurse was, unquestionably, Florence Nightingale, the founder of modern nursing. In addition to her own wisdom and insight, she was the product of the 19th, sometimes called the "woman's century", a time when a whole galaxy of strong notable women began working for causes, reforms and progress. Catherine Coppe wrote an article called "On the Desirability and Utility of Ladies Visiting the Female Wards of Hospitals and Lunatic Asylums". Mrs. Jameson urged the bitter need of the inmates of hospitals, prisons, asylums, workhouses and reformatories, in all of which, to quote, "the poor, the sick and the delinquent were suffering for the care of compassionate and motherly women". Miss Nightingale, in founding a school of nursing, gave the necessary practical answer to these strivings. In all her teaching and writing she emphasized the psychological aspects of good nursing care. In her

continued on page 402

*An address delivered at the Centenary Celebration at Butler Hospital, Providence, R. I., on May 10, 1944.

PROLONGED REDUCTION OF HIGH BLOOD PRESSURE



Comparative effects of commonly used nitrites on systolic blood pressure in normal individuals. The action of Erythrol Tetranitrate Merck begins in 15 minutes and persists for three to four hours.

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HOSPITAL ASSOCIATION OF RHODE ISLAND

RHODE ISLAND'S OLDEST HOSPITAL

Butler Hospital, 1844-1944

PAUL J. SPENCER, A.B.

The Author. *Paul J. Spencer, A. B., Assistant to the Superintendent, Butler Hospital.*

NICHOLAS BROWN, who died in 1841, left in his Will a bequest of $30,000 "towards the erection or endowment of a . . . retreat for the Insane." This instrument further stated: "It has long been deeply impressed upon my mind that an insane hospital should be established in this vicinity upon a firm and permanent basis under an Act of Legislature where that unhappy portion of our fellow citizens who are by visitation of Providence deprived of their reason, may find a safe retreat, and be provided with whatever may be most conducive to their comfort and to their restoration to a sound state of mind."

As a result of the petition of a group of leading citizens of Providence, known as the "Incorporating Committee," a charter was granted by the Legislature of the State of Rhode Island, at its January 1844 session, for the establishment of the "Rhode Island Asylum for the Insane."

Shortly after this a prominent merchant of Providence, the Honorable Cyrus Butler, agreed to give the sum of $40,000 toward the establishment of such an institution and the creation of a suitable building, providing an equal sum be raised by subscriptions, in order that an amount of $50,000 could be set aside as a permanent endowment fund from the total of $110,000 thus available. These conditions were fully complied with, and on October 19, 1844, a tract of land, once known as the "Brick House Farm," and latterly as the "Grotto Farm," containing one hundred fourteen acres of land on the banks of the Seekonk River, was acquired for the sum of $6,000. Upon this land was a brick residence, the Richard Brown House, now believed to be the oldest brick house still standing in Providence. It is still used as a residence by Hospital personnel.

On November 8, 1844, the Trustees voted to name the new institution "The Butler Hospital for the Insane" in honor of its most generous benefactor.

Thus Butler Hospital became not only the first mental hospital in Rhode Island but the first hospital of any kind in the State.

The Trustees engaged the consulting services of Dr. Luther V. Bell, Superintendent of the McLean Asylum near Boston. Dr. Bell spent several months in England and on the Continent studying the most recent ideas on the construction and function of mental institutions, returning in the late spring of 1845 with plans in mind embodying the best features of the structures he had seen. Together with the Superintendent of the Maine State Asylum in Augusta, Dr. Isaac Ray, whom the Trustees had engaged to be the first Superintendent of Butler Hospital, Dr. Bell worked out the design of the original buildings which still comprise the nucleus of the present-day Hospital. Ground was broken for the building in the autumn of 1846, and Butler Hospital opened its doors to receive the first patients on December 1, 1847. Of Tudor-Gothic architecture, built in the shape of the letter E, running two hundred ninety feet in length, with some one hundred thousand square feet of floor area, the Hospital was designed to accommodate about one hundred patients, and cost $89,000 to erect.

True to the spirit of its founders, whose desire was to help the "indigent insane" populating the poorly kept almshouses of the State, the weekly rate for care and treatment was set at $2. Despite rising costs, the rate was held below $3 a week for a number of years, the income from the Permanent Fund being used to make up the operating deficit.

Through the years extensive alterations and additions to the buildings have been effected. The Duncan, Sawyer, Goddard and Weld Houses and Weld Infirmary were added as wards for patients, additional quarters were built for personnel, and Ray Hall was constructed with complete recreational and occupational facilities. The stable has been converted into a large and fully equipped gymnasium; a hobby shop, industrial shop, conservatory and superintendent's and doctors' residences have been erected. Extensive landscaping has rendered the present one hundred thirty acres a retreat of beauty and charm.

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PSYCHIATRIC NURSING

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Notes on Nursing one finds "the nurse must distinguish between the idiosyncracies of patients. One likes to suffer out all his suffering alone, to be as little looked after as possible. Another likes to be perpetually made much of and pitied and to have someone always by him."

Soon after Florence Nightingale led the way, schools of nursing were started in this country, among them a number in hospitals for the care of psychiatric patients. Superintendents of these hospitals soon found that the systematic instruction of nurses was followed by considerable improvement in the nursing service in a variety of ways. Benefiting from this experience Butler Hospital opened a school of nursing in 1895. Under the efficient and far-seeing direction of Miss Sarah Parsons, the first superintendent of nurses, the foundations were laid for the wise, intelligent, liberal teaching of student nurses which has characterized the school. From the beginning certain principles were established which show the wisdom of the founders. Miss Parsons and Dr. Blumer, superintendent at that time, both recognized that psychiatric nursing is a part of general nursing education and recommended an affiliation with a general hospital. In 1909 such an affiliation was effected with Bellevue in New York City. Four years before this an affiliation was established with the Providence District Nursing Association whereby each student spent eight weeks in the public health nursing field, thereby gaining breadth of vision as a nurse and in turn contributing to public health work her own understanding of psychiatric problems.

In recommending this step Dr. Blumer wrote "It seems to me that the moral effect upon this community of having the pupil nurses of Butler Hospital engage in the work of general nursing will be very great in inculcating the doctrine that diseases of the mind are diseases of the brain, dependent upon tissue changes or functional disorders of that organ, and not to be viewed otherwise by the public than as other diseases of the body. Year after year and decade after decade alienists have been preaching this doctrine in season and out, but it still seems even in this enlightened age, that it is almost a primitive instinct of our race to look with dread upon the insane, or, at all events not regard them after the manner of other sick folk. Pupil nurses from Butler Hospital mingling among the sick poor of the city of Providence during eight weeks of their training, would be able to accomplish much in the fight against prejudiced and ignorant conceptions."

Similarly, it was early recognized that the medical staff must assume responsibility for the teaching of student nurses. This obligation placed additional burdens on the doctors, but was willingly accepted. The school has consistently had generous and helpful cooperation from the medical staff in the teaching program. At the same time the extra expense of having a school was acknowledged to be justifiable because of the improvement in the care of patients.

Dr. Blumer in his annual report in 1902 showed appreciation of the value of the school to the hospital and expressed his ideal of the kind of nurse the institution desired to produce. He wrote "To state that at the beginning of the year the number of pupils was fifty-four, that during the year seventy-eight probationers were admitted, that seven members graduated, and that the year closed with a staff number of fifty-seven, feebly expresses the vitality of the school. The vigor of the school must be determined, as well by its esprit de corps, as by the growth of those higher faculties, so essential in hospital service, the power to recognize quickly and record intelligently important clinical data, and by the attainment of a broadening ethical culture, particularly in reference to the "psychic factor" as a part of daily routine. Considering the evolution of the stage of scientific treatment of the mentally ill from the merely custodial of the dark ages through the domestic period recently closed, pardon may be granted if we congratulate ourselves on having within the few years of the school's existence made considerable progress on lines referred to, still striving to inculcate proficiency in the nurse's domestic relations, yet ever holding them subservient to the higher purpose."

Through the years the school showed a steady growth, every change being weighed with conservative caution but the dominating plan of "harmonizing the largest service to the patients with the greatest good to the pupils in training" being strictly adhered to. Dr. Ruggles and Miss McGibbon have carried on consistently the ideals of the founders of the school showing a liberal progressive attitude toward necessary changes and an awareness of the part that psychiatric nursing plays in all nursing education.

Progress in Nursing Education

In due time the nursing profession, through the activities of the National League of Nursing Education and other organizations, took up in earnest the study of nursing and nursing education in this country. As a result of the study, it seemed advisable to recommend that student nurses be taught the foundations of nursing in a general hospital and psychiatric nursing through affiliations with psychiatric hospitals. This was obviously the first step toward making psychiatric nursing an integral part

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drafted to serve their country. Even now, when in a military sense the handwriting is on the wall for the forces of dictatorships, unscrupulous propaganda is striving increasingly to make us suspicious of our Allies and they of us, trusting in the dictum: "Divide and conquer".

Utilization of Honest Propaganda

Is there such a thing as honest propaganda? There is. Psychiatrists use it every day. They employ it with their patients in order to convince them that the world of reality from which their mental illness has removed them is after all a much better world than the land of unreality in which they are living.

In order to be successful, psychiatric propaganda must be truthful; the psychiatrist himself must have faith in it; it must deal not only with the present situation but also with the future and contain the understanding that if feasible, the too hard and too unfair conditions of the patient's everyday life will be eased. It cannot accomplish its aim by cold, clear logic but it needs the momentum that comes from emotional warmth and enthusiasm. Finally, it must be sold to the patient. A man may make a perfect thing, perhaps a mousetrap so cunningly contrived that mice would come from far and wide squeaking to be imprisoned in its meshes, but unless there was sales talk, the public would never know about it and would not buy it to catch mice.

National propaganda must have the same qualities as the propaganda we use with our patients. It must be honest. If anyone objects that honest propaganda "won't work" the answer is—"How do you know, it has never been tried".

We must have faith in our propaganda. Surely this should not be too difficult. Our democracy and any democracy will never achieve Utopian perfection, but it is true that not only in our present troubled condition, but as far as legitimate promises for the future will be redeemable, our country gives more and offers more to every man, woman and child than any nation in the world.

Like anything else, even a country must be sold to its people. This is particularly true of a democracy, for a democracy dare not ruthlessly stamp out unscrupulous propaganda. Often on the surface it is not to be distinguished from honest propaganda, and a democracy dare not risk the extinction of its intelligent minorities. Honest propaganda is not allergic to the emotions. It should be presented warmly and stirringly and not only with cold factual detachment. Our nation would scarcely have been conceived, and if conceived it would have been stillborn, if it had not been for the enthusiastic momentum imparted by patriotic fervor. The nation would never have survived its crises had it not been for the self-sacrificing emotional devotion of the people.

Both deceitful and truthful propaganda must make use of the symbol. Psychiatrists need scarcely be warned that the symbol is dangerous and may dethrone reason and enslave the emotions. Too often have psychiatrists witnessed the degradation of the symbol from its legitimate function of condensing and economizing thought and speech, in the reduction of the once nobly functioning human mind to a dirty scrap of cloth or a few vapid words or manneristic gestures.

In somewhat similar fashion does unscrupulous propaganda prostitute the symbol. There is the hushed, expectant silence; the shrill blast of the trumpet; the roll of the drums; the entrance of the high priest; the presentation of the symbol, sometimes a reverently intoned formulae of words; often the replica of some object usually of noble traditional lineage. Then, indeed, is intelligence dethroned and any utterance at all, however banal, serves to unleash bestial passions.

In honest propaganda the symbol serves a legitimate purpose. It serves to economize thinking and speaking and to produce emotional warmth and enthusiasm. A symbol is as good as the thing it symbolizes, and is an acceptable and necessary part of everyday life. A cheque is a symbol for money—a good symbol of the money in the bank. A kiss is a symbol of trust, friendship or love—unless it be a Judas kiss of betrayal. In certan religions there are beautiful symbolisms expressive of the boundless love and compassion of the Creator. So, too, are the flag and the national anthem symbolic of our patriotism. They should stir us emotionally.

There is too much of a tendency to look "down nose" at public displays of patrotic fervor and think of them as non-intelligent. This is not only supercilious but untrue. Robust displays of patriotic feelings are good for us and for our nation.

Psychiatric Definition of Democracy

If Psychiatry were asked to define Democracy, the definition it would give from its many years of experience would not be sentimental but very realistic. Psychiatry knows that all men are far from being equal. Even at birth there are the inequalities of inheritance. Riddle said: "All men are created unequal. No politics of poetry or dogma in this; just a straight, clean fact of prime importance to decent thinking on human social problems; and possibly a fact that must be learned, digested and assimilated before unreason ceases to be a threat to all democratic forms of Government."

continued on page 410



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DOCTORS AT WAR

THE SERVICEMEN'S READJUSTMENT ACT OF 1944

(The G. I. Bill of Rights was approved by the President June 22, 1944, as Public Law 346, Seventy-eighth Congress. The following abstracts from an analysis of the measure by the legal department of the AMA are published that medical officers who are veterans of this war may be familiar with some of the benefits made available by the new law. — The Editor)

Title I

This title deals generally with hospitalization, claims and procedures, aid by veterans' organizations, and the review of discharges or dismissals from the armed forces. It authorizes an appropriation of $500,000,000 for the construction of additional hospital facilities for veterans; it provides for the detail of commissioned, appointed or enlisted personnel from the armed forces to the Veterans' Administration for periods not extending beyond six months after the termination of the war; it makes available adequate training in the use of prosthetic appliances in a Service or a Veterans' Administration hospital, "or by out-patient treatment, including such service under contract"; and it sets up machinery for the review of certain discharges or dismissals from service.

Title II

This title of the law provides a program for the education of veterans following separation from service.

Eligibility for Benefits.—Persons who served in the active military or naval services on or after September 16, 1940, and prior to the end of the war, for the prescribed length of time, and who shall have been released or discharged under conditions other than dishonorable, will be entitled to the benefits of this title.

Veterans must have served 90 days or more or must have been released or discharged from active service by reason of an actual service-incurred injury or disability. This 90-day period is in addition to any period spent under the Army or Navy training programs which were a continuation of a civilian course pursued to completion.

An otherwise eligible veteran over 25 years of age must show that his education or training was impeded, delayed, interrupted or interfered with by reason of his entrance into service in order to qualify for the additional education or training made available under this title.

An otherwise eligible veteran will be entitled, too, to a "refresher or retraining course" if he so desires.

Onset, Length, and Termination of Courses. – A course must be initiated not less than 2 years after either the date of the veteran's discharge or the end of the war, whichever is later. No training will be afforded beyond 7 years after the end of the war.

An eligible veteran will be entitled to education, or training, or a refresher or retraining course for a period of one year, or the equivalent thereof in continuous part-time study, or for such lesser time as may be required for the course of instruction chosen. On completion of the one year course, other than refresher or retraining course, the veteran will be entitled to an additional course not to exceed the time he was in service after September 16, 1940 and before the end of the war.

The total period of education or training may not exceed four years.

Educational Institutions.—The veteran may select any approved institution to attend which will agree to accept or retain him. For reasons satisfactory to the Administrator of Veterans' Affairs, the veteran may change a course of instrutcion. If the progress of the veteran is unsatisfactory, the Administrator may terminate the course.

Payment to Educational or Training Institutions. —The Administrator will pay to each institution for the veteran enrolled the customary tuition cost

continued on next page

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SERVICEMEN'S READJUSTMENT ACT

continued from preceding page

and such laboratory, library, health, infirmary and other similar fees as are customarily charged. The Administrator may pay for books, supplies, equipment and other necessary expenses, exclusive of board, lodging, other living expenses and travel, as are generally required for the successful pursuit and completion of courses by other students.

Payments by the Administrator may not exceed, with respect to any veteran, the sum of $500 for "an ordinary school year."

Maintenance Allowances: — While enrolled in and pursuing a course, a veteran will be paid a subsistence allowance of $50 per month if without dependents, and $75 a month if he has a dependent. Attendance on a part-time basis, or productive labor providing compensation during the course period will reduce these allowances.

Title III

This title sets up machinery whereby loans will be made to Veterans for the purchase or construction of homes, farms, and business property. Provisions for loans include (1) for the purchase, construction, alteration, repair or improvement of property to be occupied by the veteran as his home, or the payment of delinquent indebtedness, taxes, or special assessments on residential property owned by the veteran and used by him as a home, and (3) the purchase of any business, land, buildings, supplies, equipment, machinery, or tools to be used by the applicant in a gainful occupation, other than farming.

The aggregate amount guaranteed by the Veterans' Administration may not exceed $2,000 in a particular case nor 50% of the loan negotiated for the purposes indicated. Provision is made for the guaranteeing of a second loan under specified conditions. Application for the guaranty of a loan must be made within 2 years of separation from service or within 2 years of the termination of the war, whichever is later, but may not be filed later than 5 years after the war.

Interest for the first year on the guaranteed part of the loan will be paid by the Veterans' Administration and thereafter the interest on guaranteed part of the loan may not exceed 4%. The guaranteed part of the loan is to be repayable in 20 years.

Title IV

This title contemplates a job counseling and employment placement service for veterans to be operated under the U. S. Employment Service with the cooperation of the Veterans' Placement Service Board.

continued on page 417



In treating those who recklessly "eat on" extra pounds, the physician may recommend a low calory diet which fails to achieve vitamin balance and thus afflicts the patient with a more serious condition than obesity. While chastening these patients on grapefruit and lettuce, the doctor can supplement their daily diet with one of Upjohn's small, easy-to-take vitamin preparations and provide an indispensable minimum of protective vitamins without the material addition of calories. Upjohn's penny-wise vitamins, small in size, high in potency, ensure *safe* reducing diets for the pound-foolish.

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† Brennemann, Jas., Amer. Med. Asso., Vol. 60: 575-582; 1913.

* Espe and Dye — "Effect of Curd Tension on the Digestibility of milk." Amer. Jour. Dis. Child. 1932, Vol. 43; P. 62.

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CONTRIBUTION OF PSYCHIATRY TO MORALE

continued from page 405

Immediately after birth and throughout life there is the operation of many inequalities largely derived from the five evils cited by Southard: Ignorance, Poverty, Disease, Crime and Legal Entanglement. Psychiatry might propose this definition of a democracy: An acceptance of natural inequalities but with the endeavor to lessen the penalties incurred by the individual who suffers them and a constant and unremitting effort to remove artificial inequalities.

I have indicated only a few of the many contributions which Psychiatry has made to democratic morale.

Eventually and by the mercy of God this cruel and bloody war will cease. Then at the Peace Table there will be a sincere effort to insure the Peace. It is to be hoped that Psychiatry will have a voice in the deliberations. Psychiatry has served a long and faithful apprenticeship in an intensive study of the individual in health and disease. It is now ready to make application of what it has learned to human society en masse. Psychiatry is at the dawn of its social era.

Certainly the humane disciplines deserve respectful attention. Political diplomacy has not been glowingly successful. At best it may be counted upon to produce a precarious balance of armed power—a temporary rearrangement of boundaries. Finance has not yet given a workable answer. Indeed, some of its formulas might make one believe that mathematics in its higher flights is akin to poetry and a few of its devices if proposed a decade ago would have been labelled grandiose delusions.

To the Trustees; to Dr. Ruggles and his Staff; to the employees and many friends of Butler Hospital, I bring from your sister institution, the Pennsylvania Hospital greetings and felicitations. Personally I give you this Centenary wish: May this noble edifice survive for many centuries and may the scientific and humanitarian lessons learned in its halls and so freely taught to others, Butler's contribution to democratic morale, never be effaced from the minds and hearts of men.

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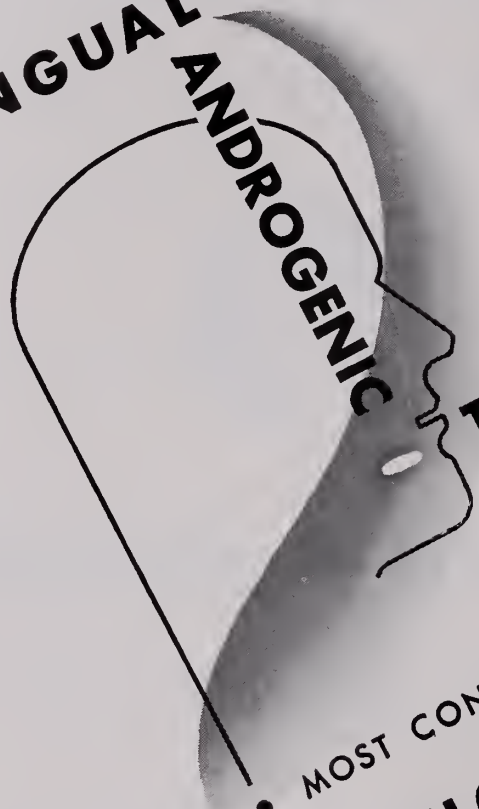
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[1] Biskind, G. R.: Proc. Soc. Exper. Biol. & Med. 43:259, 1940. Burrill, M. W. and Greene, R. R.: Endo. 31:73, 1942.

[2] Lisser, H. and Curtis, L. E.: J. Clin. Endo. 3:389, 1943. *Trade Mark Reg. U. S. Pat. Off.

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PSYCHIATRIC PROBLEMS IN WAKE OF WAR

continued from page 386

I reminded you a while ago of Heraclitus' "Man is the measure of all things." May I also recall the following words of this Greek philosopher: "If I can prove to you that Athens is governed by laws that are just, I will have said an adequate eulogy in the memory of those who died for her." The apposition of these two sayings of Heraclitus' plainly suggests that the greatness of man cannot be measured outside the goodness of the society in which he lives. I should like to emphasize, by way of warning, that in stressing the value of the individual man I should not care to relieve him — his greatness to the contrary—from his obligation to remain in a state of humility. It is true, as Anatole France put it, that "What is admirable is not that the world of stars is so vast, but that man was able to measure it"; and while this is true, we must not forget the answer which the Muse gave to the same Anatole France when he queried her about the genius and the destiny of men. The Muse told him, among other things, that man's original pagan gods "gradually dropped their ancient cruelty, and became disgusted with the shedding of blood of their victims; some of these gods, like Aphrodite and Pallas, even shined with the brilliance of wisdom and beauty. But, for the most part, they limped behind the progress of the human mind. They remained jealous and unjust. Man then came to see that these gods were but the memory and the image of his own terrors which had vanished, and he stopped believing in them. He then had no other god but his own genius. He measured the universe; he weighed the sun; he split atoms.

"But the essence of things was not revealed to him. He remained the toy of appearances, and he knew not his origin or ends."[2]

Let us therefore bear in mind that being in love with his genius does not add to man's greatness or knowledge. Sometimes it is not the measuring of the vastness, but the appreciation of the infinity of it that adds knowledge.

This philosophical digression should make it easier for us to face and appreciate properly the fact that psychiatry has become a little more than a purely therapeutic discipline; outside its purely therapeutic endeavors and scientific research, psychiatry has become preoccupied with problems of delinquency, crime, and social psychology in general. Some years ago, Dr. William Alanson White, speaking before the American Bar Association, stated that psychiatry had invaded the field of sociology. While this is undoubtedly true, it would perhaps be more true if he had said that social problems imposed themselves upon psychiatry and psychiatry accepted the challenge and the task.

It is in this field that psychiatry faces its major problems as a result of this war. The very best intentions and efforts, and even the best gifts of brevity, would be hopelessly thwarted if one were to give here a complete outline of these problems. Little more than mere allusions can here be attempted.

Let us for a moment set aside the various rational motivations which make us fight this war and make us lend every effort to achieve an absolute and victorious end. Let us glance into the dynamic psychology and not the rationalist economic, cultural, and political aspects of war.

Man fights to kill. Man learns to kill. He need not learn to die, even to die heroically, but he must learn openly to hate and to destroy and to kill. He must learn the tragic necessity of destroying all those things which in peacetime he learned to value most highly as the best achievements of our civilization—railroads, food and water supplies, sewage systems, homes, libraries, churches — everything that stands in the way of victory, everything that the enemy needs or uses. This is as it should be. Yet this psychology of destruction, of disregard of life and property and of many purely cultural values such as civility, mutual respect, and trust, is not limited to the men in battle. The men in the foxholes must divest themselves of many attributes of our daily peace-civilization—they must do or die. But the civilian population is subject to the same psychological shift. We rejoice when we hear how many of the enemy were killed or starved into submission, with sorrow we count our own dead, and with this sorrow we nurse a rightful hatred of those at whose hands our own were deprived of their lives. This hatred of the enemy cements national unity.

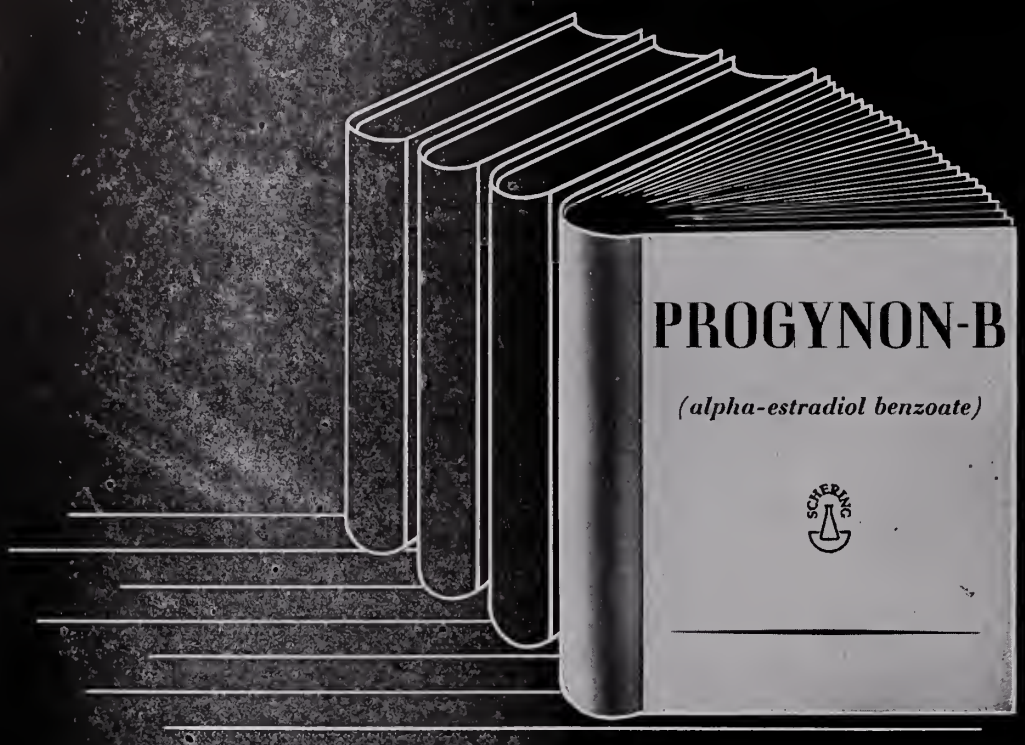
It makes us the potent combat unit which we must be at all cost. Yet the costs *are* high. We pay the price with stern determination, but in doing so we also devalue many of our cultural treasures. When we hear that Florence was bombed, we rightfully rejoice, and we force ourselves to forget that it is Florence where Michelangelo and Savonarola lived, worked, created, and kindled the fire of faith and hope and beauty.

When we hear that Salerno was destroyed, and Monte Cassino reduced to rubble we stand in awe contemplating the sacrificial greatness of our young men, over whose bodies and through whose blood our destiny leads us to liberation from tyranny. So we rejoice in the new ruins of Salerno and the rubble of Monte Cassino—but we do pay a price for this joy. We think of Salerno and Monte Cassino as military objectives. We must and we do

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[2]Anatole France, "La terre et l'homme," *Oeuvres complètes.* (Paris, Cadmann-Lévy, editeurs, 1925), XXV, 359.

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BACK THE ATTACK . . . WITH WAR BONDS

PSYCHIATRIC PROBLEMS IN WAKE OF WAR

continued from page 413

force ourselves to forget that Salerno was perhaps the only spot in the whole Christian world which for a thousand years kept, cherished, and nurtured what was left of classical medicine, in order to return it to the awakening world in the thirteenth century. We must and do force ourselves to forget that the Benedictine Monastery on Monte Cassino has been the cradle of education and medical tradition since the sixth century, that the great physician Cassiodorus worked there and that there his writings were preserved for generations to come.

Impact of War on Civilians

We must forget all this, because we must fight. And we must hate in order to fight. Imperceptibly, as if by psychological osmosis, this hate penetrates into the various layers of civilian life, stimulating social, internecine strife. Man cannot easily turn from destruction to construction, from hate to love, from revengefulness to forgiveness, from cultural relaxation to cultural restraint. Man's instinctual forces in their ebbs and flows are not easily brought under purely rational control; it is easy for him to regress a few steps below his cultural level, but it is not so easy for him to negotiate the step upward again; he always lingers a little in the trough into which he slips or falls from the top of his cultural hill.

This is why war breeds disregard for one's fellow men, and disregard of human life. This is why we find an increase in thievery, blackmarketing, kidnapping, capital crimes, and other indices of social disintegration during and particularly in the wake of war. This has been the experience of mankind since time immemorial. The classical description of social disintegration and the fall of human *mores* made by Thucydides over twenty-three hundred years ago in his *History of the Peloponnesian War* fits in more than one respect the status of human society during and after all wars, ancient and modern. This disintegration affects not only the field of economics and politics but also the instinctual cohesion of society. As is always the case with human instincts, once their integration is disturbed they break down into their primitive components and produce a lowering of *mores*. The sexual instincts become more servants of the sensual drives than of those which we call love, friendship, and mutuality of emotion. All this is the reverse side of the medal of our heroic strife, and all this produces problems of primary psychiatric concern. These phenomena are of a sociological order; they are not merely the result of the fact that our society has so many "constitutionally" wayward adolescent boys and girls, bad men and women. It is history and culture themselves that weaken their hold on the individual, and he weakens correspondingly. Side by side with heroism and self-sacrifice live hedonism, egotism; the acquisitive, sensual instincts are brought into full play.

We honor our heroes. They deserve it; we owe it to them. But in doing so we fall into a psychological trap of delusional self-righteousness, and deem to cure our social ills and many victims of our cultural catastrophe with imprisonment, capital punishment, or other judicial forms of revenge.

Psychiatry has learned that transgressions of the law, from milder forms of delinquency to capital crimes, are psycho-sociological phenomena. In this it has assumed, or ought to assume, the same attitude as the medical man in general, or the public health officer toward epidemics.

The increase of epidemics and of venereal diseases in the wake of war is not treated by way of fining every case of gonorrhea, imprisoning every case of syphilis, depriving of his civil rights every case of malaria, and executing every case of typhus.

Yet the increase in homosexuality, theft, and capital crimes in the wake of war is officially not the concern of medicine but that of the law. Psy-

continued on page 417

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PSYCHIATRIC PROBLEMS IN WAKE OF WAR

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chiatry for many years has been analyzing the psycho-sociological factors of major and minor crimes, and of recent years it has challenged the psychological, ethical, and practical validity of certain aspects of the law, which knows not of treatment but of punishment.

In the course of his long career as a clinical psychiatrist and psychiatric criminologist, Dr. White better than anyone else revealed by word of mouth and by his pen the essential motive of revenge and retribution to which society, through the instrumentality of its penal code, gives vent with an ease, conviction, and sense of justice which are psychologically untenable and morally deceptive. American psychiatry on the whole has followed White's fundamental conceptions.

In the wake of this war psychiatry will find itself better prepared than at any time in its history as a branch of medicine with psychological knowledge, sociological enlightenment, and clinical experience. Its task, like the task of the rest of medicine, will be that of reconstruction and rehabilitation of the military and civilian, direct and indirect casualties of war.

But unlike medicine and surgery, psychiatry—outside the well-defined field of the psychoses and neuroses—must also deal with clinical material which is still viewed by the penal codes as peculiarly their own. The psychiatrist therefore is forced to become a practical sociologist, and to consider one of his major medical tasks pressing social and legal reforms which would permit him in the sociological field to practice his specialty and fulfill his professional task in the light of the knowledge he possesses and professes, but which he is prevented from using freely by the superannuated tradition of punitive justice.

We may well then repeat the admonition of Heraclitus: "If I can prove to you that Athens is governed by laws that are just, I will have said an adequate eulogy in the memory of those who died for her."

SERVICEMEN'S READJUSTMENT ACT

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The title provides readjustment allowances for former members of the armed forces who are unemployed. Subject to conditions set forth in detail in the title, allowances will be paid for each week of unemployment, not to exceed a total of 52 weeks, which begins after the first Sunday of the third calendar month after June 22, 1944, and occurs not later than 2 years after separation from the service or the end of the war, whichever is the later date. No allowances will be paid for any week commencing more than 5 years after the end of the war. The number of weeks of allowances to which a veteran will be entitled, subject to the 52-week limit, will be determined by his length of service.

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WAR AGAINST FEAR AND HATE
continued from page 388

time seek for more. In this search, the little army at Butler Hospital has more than done its share.

Modern Psychiatric Conceptions

It is to the implications of the modern psychiatric conception that I would particularly call your attention. If we assume that maladjustment is the province of psychiatry, are we not obliged to think of mental illnesses in broader terms than these connoted by "hallucinations" and "delusions"? What shall we say of the chronically unhappy, the self-elected messiahs, the political agitators, the industrial misfits, the drunkards, the fire-setters, the Jew-baiters, the negrophobiacs, the double-crossing husbands, the cheating wives, the men who bribe government inspectors to pass defective cable to the war front, or the men who take these bribes? Where does the province of psychiatry, in such terms, end?

My own view, like that of Dr. Strecker and Dr. Zilboorg who have spoken here so eloquently, is that it does not end, but that it extends. In theory, at least, all these maladjustments belong to psychiatry. I believe it is only through psychiatry, through the scientific study of human behavior, human motives, human instincts, human weaknesses, human failures that we can construct a durable or endurable civilization. I believe that only thus can we put a stop to the social diseases of the world—war, poverty, slavery, unemployment, panic, waste, famine, misery and perpetuated ugliness. For these social diseases are diseases of the individual personality. Louis Pasteur said that "Two contrary laws seem to be wrestling with one another nowadays, the one a law of blood and death over imagining new means of destruction . . . the other, a law of peace, work, and health ever evolving new means of delivering man from the scourges which beset him." But it was Freud, the psychiatrist, who related these two contrary laws to the innate nature of human beings; it was he who recognized that the destructiveness of human beings is not the result of some passing fever, some incidentally occasioned accident in the normal course of life or some mysterious mob influence but the expression of a deep persistent instinct present in every individual. And it was also Freud who showed us that the impulse to live and love is likewise an instinctual endowment of human beings and a source of strength in opposition to the self-destructiveness. Die we must, ultimately, but in the meantime we can live, *if we can love.*

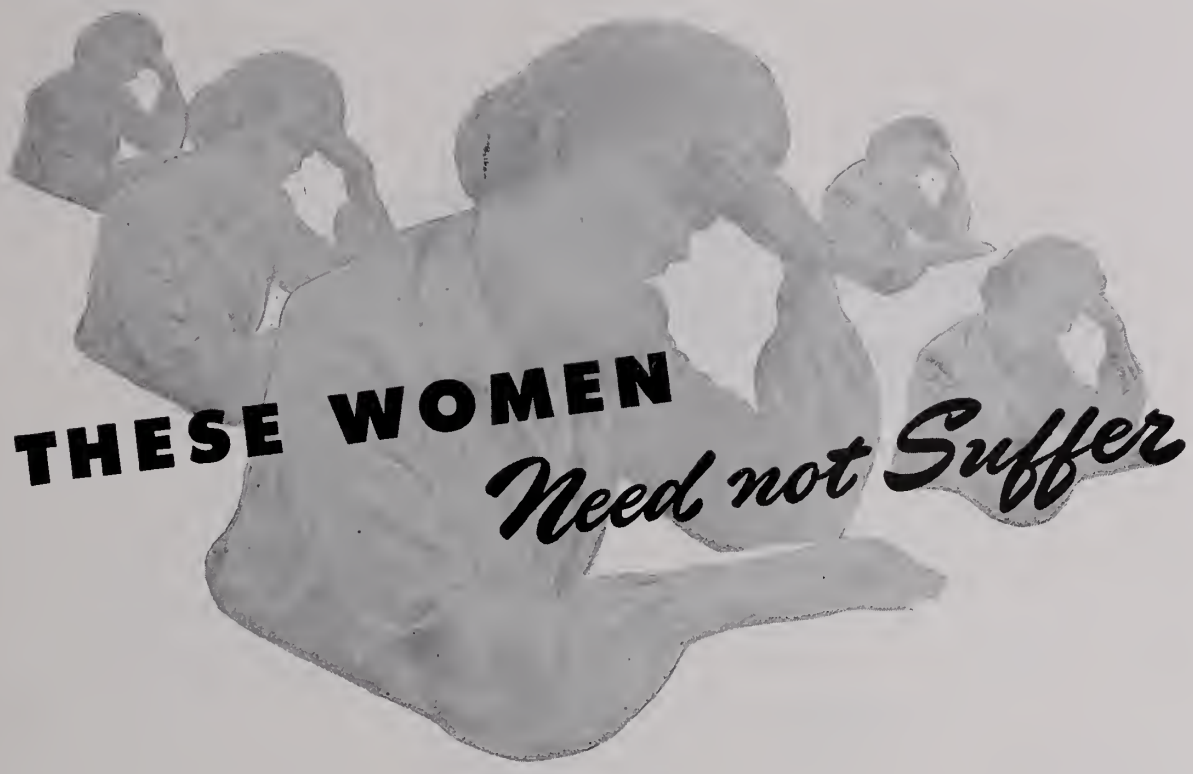
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continued on page 421

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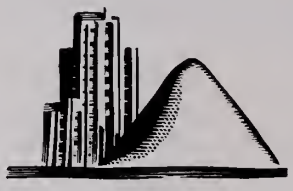
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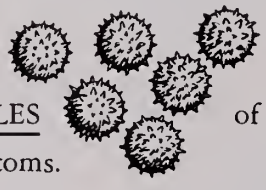
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WAR AGAINST FEAR AND HATE

continued from page 418

psychiatric hospital; it dominates the behavior of its staff from Director down to gardener. To our patients who cannot love we must say by our actions that we *do* love them. "You can be angry here if you must be; we know you have had cause. We know you have been wronged. We know you are afraid of your own anger, your own self-punishment—afraid, too, that your anger will arouse *our* anger and that you will be wronged again and disappointed again and rejected again and driven mad once more. But we are not angry—and you won't be, either, after a while. We are your friends; those about you are all friends; you can relax your defenses and your tensions. As you—and we—come to understand your life better, the warmth of love will begin to replace your present anguish—and you will find yourself getting well."

It is not easy to maintain and to implement such an attitude and such therapy—but it is the program of modern psychiatry. It is, I know, the program of Butler Hospital.

Scientists, doctors, psychiatrists are not alone in seeking to solve the great problems of the individual or the problems of groups, of society. In a sense, *every* thoughtful person strives to do what he can to make the world a better place to live in. But the fact is that while we have made some progress, with the aid of religion, education, political science, economic theory, social organization, we are still painfully far from our goal, and it seems to some of us that the application of science, psychological science, the science dealing with personality structure and personality function ought to yield more fruitful results. It has never been tried, really; even today we know far more about airplanes and radios than we do about human minds, and for the most part consider them (the former) more important.

This is why the battle waged by the psychiatrist against the hate and fear that have made his patient ill is at the same time a battle for human happiness and betterment. I think of this, and I believe my colleagues all do, when the long weary hours of work devoted to a single sufferer stretch out over monotonous, discouraging months and even years. It is not just for John Smith that I am patient and steadfast and unflagging—it is not just for him, or even for his family, or for science. It is for the world. It is for the better world that my children and my grandchildren shall live in.

This is my credo and my faith and my hope. This is why I am proud to stand and bear witness to my reverence for the founders of an institution that has carried on with this same faith for one hundred years, my gratitude to a community with the continued vision to make that possible, my inspiration from the lives and work of the men and women that have been and that are — Butler Hospital.

FUTURE OF VOLUNTARY HOSPITAL

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and control, to work in teams and groups. It has played the determining role in creating the nursing profession. As an institution offering scope and outlet to the energies of public spirited men and women in behalf of the public welfare the voluntary hospital has satisfied, and I think will continue to satisfy, the remarkably useful activities of sensible leaders who enjoy being helpful under any kind of circumstances.

If the voluntary hospital has had any conspicuous defect it is this: that despite its intensive excellence it has frequently been reluctant to see the complete picture of community need. Generosity and vanity sometimes twine upon each other: the outstretched hand betimes has a possessive grasp. And the comfort of having agreeable companions in benevolence can blind such friendly companions to the inadequacy of their work.

But in the main, clinical medicine in America owes no debt greater than to the voluntary hospital, that whether dominated by piety or by efficiency, has always held out to physicians and nurses the most loyal and devoted aid to their best efforts. That is the greatest value of the voluntary hospital. That is the significance or relationship to medicine most worth continuing and preserving in the future.

Changing Values Affect Future Plans

Now there is one question which remains uppermost in all our minds. Stated in language whose simplicity does scant justice to the less obvious complexities of the situation the problem is sometimes posed thus: "If the increasing rate of taxation takes so much away from the well-to-do that they can't afford to continue their benevolent gifts what will happen to the voluntary hospitals?"

continued on page 425

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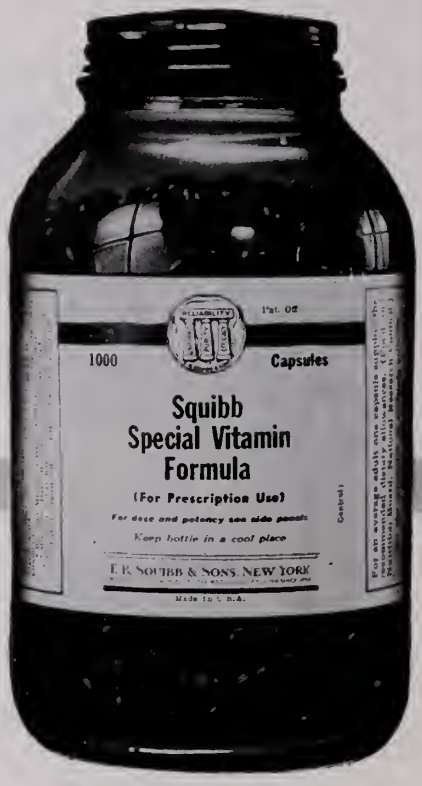
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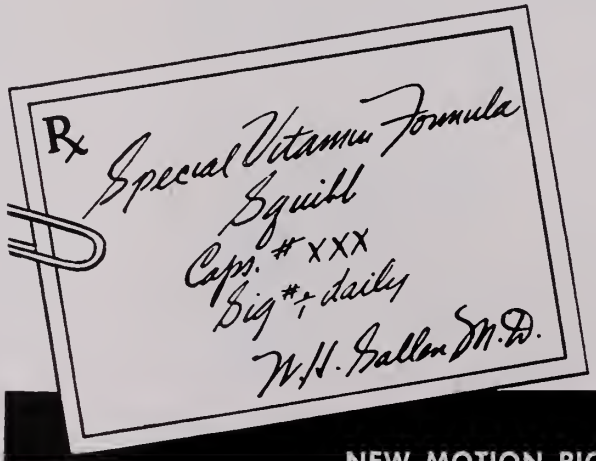
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FUTURE OF VOLUNTARY HOSPITAL

continued from page 421

It seems to me that the answer is: if the voluntary hospitals will so change their form of organization and their type of function as to retain or acquire values and relationships not possessed by the present tax-supported institutions they will survive on government subsidy and yet autonomous enough to satisfy their trustees and administrators. Otherwise they will take varying lengths of time to expire, depending on a wide variety of circumstances. The values and relationships I should like to see retained or acquired by voluntary hospitals are those related to initiative, independence, leadership and qualitative experimentation with new methods of medical care. In more explicit terms, the voluntary hospitals should take research and teaching as their peculiarly appropriate functions since research and teaching will always demand and usually secure a larger measure of independence, leadership, initiative and quality as contrasted with quantity of performance. Now to assume the functions of research and teaching, especially in interneships and residencies, involves stipulated and organic relationships with medical schools and universities, not as a merger but as a partnership. My personal faith is that society—even a heavily taxed society—will protect teaching and research from political and administrative interference more zealously and more constantly than it will shield mere hospital work. We want our own sons and daughters in their student years to have freedom and the best examples to follow—every generation wants that chance for its youngsters. And the importance of freedom for research will never lack champions.

One further step the voluntary hospitals must take to assure their futures. Medical care is changing from the status of a private luxury or a blessed benevolence to the status of a civic right. As an important consequence hospitals are going to be organized on a regional basis and with a weight of public opinion that will override the intransigent independence of institutions that refuse to collaborate. Therefore explicit and attentive care should be given by the boards of voluntary hospitals to their role in an effective general scheme of medical care. I do not recommend that they fall over themselves to accede to the first plan that comes along, but I do believe that if with no recognizable and singular qualifications except those of pride and historical traditions they refuse to get into gear with a rational and well considered scheme of regional medical care they will invite their own decline and disappearance. Hospital insurance might delay the final failure—I cannot believe it would prevent eventual breakdown.

In conclusion this then is my thesis: that to ensure a thoroughly satisfactory future for the voluntary hospital we should study its past and present relationships to the rest of society and life, and we should endeavor so to change its form and function as to maintain and acquire for it a value and significance which is peculiar and appropriate. This value will come from developing teaching and research far more intensively than at present, and from adjusting the hospital to regional needs, relying upon the quality of its contribution in teaching and research rather than upon the quantity of mere medical care.

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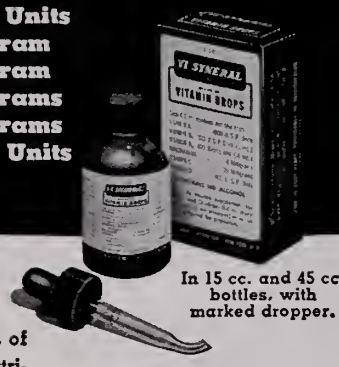
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PSYCHIATRIC NURSING

continued from page 402

of all nursing education, a goal which has not yet been fully attained. This recommendation, and the recognition of the fact that the money expended for the school of nursing at Butler could be used to greater advantage to meet the increasing requests for affiliating courses from other schools of nursing, influenced the decision of the Board of Trustees, in 1939, to terminate the three year course. A total of 532 nurses, 168 men and 364 women, graduated from this school during its 40 years of existence. Many of them are leaders in the psychiatric and other fields of nursing and the hospital may well be proud of its contribution.

Numerically an even greater contribution has been made by Butler Hospital through its well established affiliating course which meets the needs of student nurses from many different schools. In 1917 Butler Hospital received its first affiliating student from the Memorial Hospital in Pawtucket. Since that time over 2000 undergraduate students have benefited from the very excellent program offered. In addition, through arrangement with the Rockefeller Foundation, the hospitality and educational facilities of Butler Hospital have been offered to over 70 graduate nurses from the United States and Canada and from many foregn countries who have come here for instruction or observation in psychiatric nursing. All of these students, undergraduates, affiliates and graduates, have gained an insight into the emotional problems of all patients as well as an understanding of psychiatric patients, which is invaluable to them in any field of work.

These examples, from the remote and recent past, have been given in an endeavor to show that the principles of psychiatric nursing are essential for the nursing care of all patients. Nurses who are imbued with these principles utilize them in their work and incorporate them in their teaching whether or not the subject is primarily psychiatric nursing.

The big contribution of psychiatric nursing in the past has been the individualization of the patient—appreciation of him not as a case, nor as a vehicle for some interesting disease process but as a person with his own individual psychological and physical make-up, a person who will react in his own individual way to his illness, whatever label his illness bears. Through this teaching the nurse has come to understand why one patient's emotional reactions may be quite different from those of the patient in the next bed who may have the same pathology. The influence of the emotional factor

continued on page 429



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PSYCHIATRIC NURSING

continued from page 427

in the progress of an organic illness is only beginning to be understood, but the recognition of its importance is due to the teaching of psychiatrists.

But it has been said that the American social order is coming out of individualism into group life. The present trend in nursing education is toward an understanding of the patient as a member of a family, of a community, of society. He is a product of the interactions of social forces and his own inherited constitution. The psychiatric nurse is taught to appreciate the importance of the patient's immediate environment, his clothes, the people about him, the color of the walls of his room, or the general atmosphere of the ward in which he lives. It is but a step to extend the term environment to wider horizons.

Psychiatric Nursing of the Future

The programs of psychiatric nursing in the future will give the student not only the skills necessary for dealing with individual psychiatric patients, not only an appreciation of psychosomatic interactions but true understanding of the community. She must know to what extent the patient's family and social milieu have influenced his behavior, the psychological and economic problems of mental illness in the community and she must be a part of the community herself in order that she may interpret mental illness and teach the importance of sympathetic acceptance and intelligent care of mentally ill persons. With this broader concept of environment psychiatric nursing fits in with and contributes to nursing education as a whole.

Quite recently there has been established in Oxford University a chair of Social Medicine. This is not to be confused with socialized medicine, nor is it another name for preventive medicine. Its purpose is to overcome the tendency of medicine, during the past quarter century, to become not merely more specialized but also more technical. Dr. Ryle, Professor of Social Medicine says that in the process "the old etiological interest and humanism of our fathers have tended to take a second place". More and more technical instruments are used in the science of diagnosis and "less and less intimate understanding of the patient as a whole man or woman with a home and anxieties and economic problems and a past and a future and a job to be held or lost. — The sciences and techniques have come to dominate medicine to the exclusion of the most important science of all—the science of man —and the most important technique of all—the technique of understanding. Science without humanism may work with atoms but it will not work with men."

It is inevitable to a certain degree that as the science of medicine develops and changes so must nursing alter its techniques. At a certain period in the history of nursing, because of the scientific discoveries of Koch, Pasteur, Lister and others and the resulting change in medical techniques, more emphasis was placed in nursing on specific skills and the original concept of Florence Nightingale of nursing as the art of *caring* for the patient was lost sight of.

Today the philosophy of nursing education proves that the art of nursing has been recaptured. The goal of nurse educators that every student nurse be given the "psychiatric point of view" not only in a few weeks or months of an affiliation at a psychiatric hospital, but throughout her nursing education will help to obviate the problem, found in nursing as well as in medicine and so ably expressed by Dr. Ryle. When this goal is reached the nurse's art of understanding will be immeasurably increased.

Harvey Cushing once differentiated between the thinkers and the doers, giving as an example of the thinker the psychiatrist who chooses to solve his problems in the study, and of the doer the surgeon or laboratory worker who prefers to work them out with his hands. It is hardly fair to lift this statement out of its context because Dr. Cushing would be the first to acknowledge that surgeons

continued on page 435

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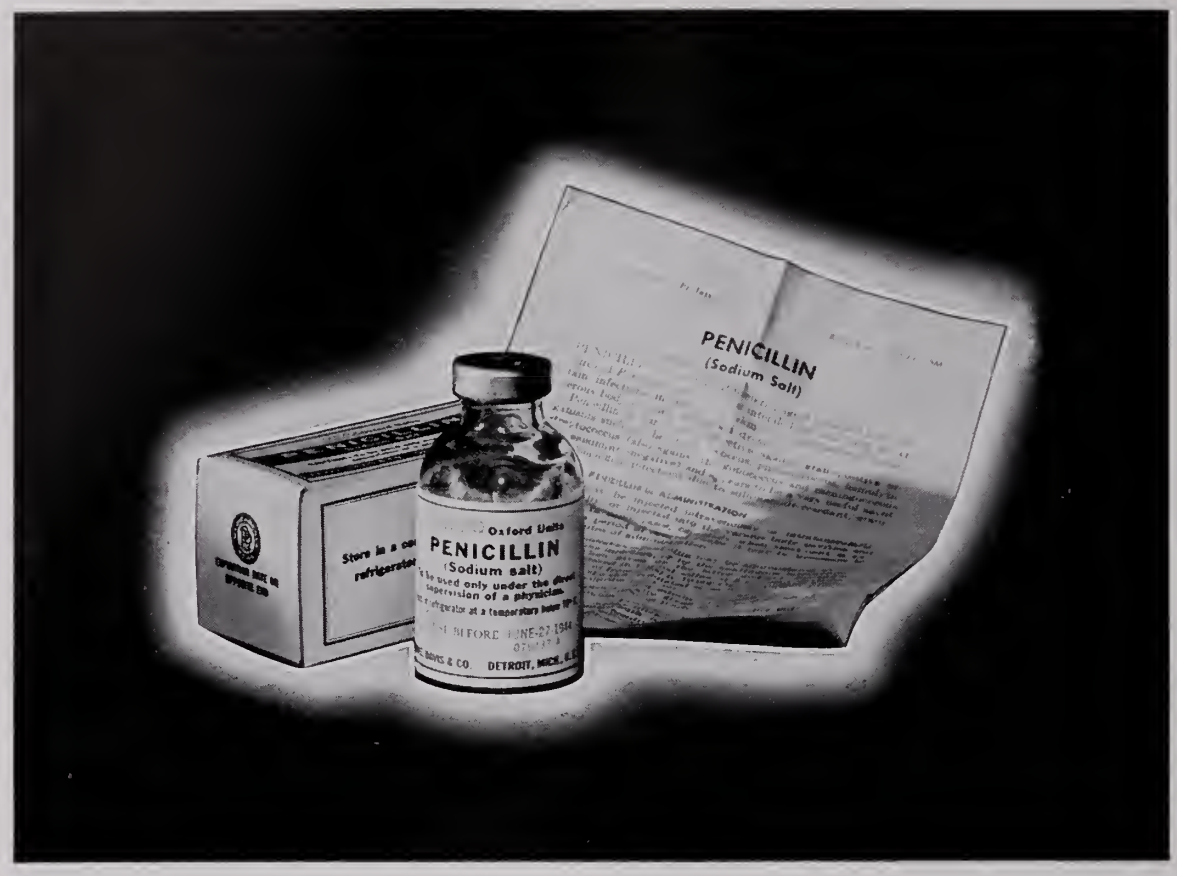
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RHODE ISLAND'S OLDEST HOSPITAL

continued from page 401

Today there are accommodations for one hundred seventy-five patients together with the clinical and laboratory facilities of a modern hospital.

The buildings now occupy approximately four hundred thousand square feet of floor space and with equipment have a value of $1,970,000. The book value of its invested funds at present amounts to $1,287,285. Facilities for medical care and treatment of patients are maintained at optimum level by a staff of resident physicians who carry on the Hospital's pioneering leadership at the beginning of its second century of psychiatric endeavor. Of its six Superintendents, four have had administrations of twenty years or longer. Leaders in their chosen field, three of them have served as Presidents of the American Psychiatric Association—Dr. Isaac Ray, Dr. G. Alder Blumer, and the present Superintendent, Dr. Arthur H. Ruggles.

The Hospital has maintained a School of Nursing for half a century, and at the present time admits yearly over two hundred and fifty affiliating student nurses from fourteen general hospitals for a course in psychiatric nursing.

Butler Hospital is an incorporated institution administered by a Board of Trustees who have maintained an unbroken record of weekly visits throughout the wards for an entire century. This record is, perhaps, without parallel in the annals of American medical institutions. Many of the Trustees carry on a family tradition of service to the Hospital, and it is interesting to note that one of the members of the Board and Chairman of the Centennial Committee, John Nicholas Brown, is a great-grandson of the original benefactor.



BOOK REVIEW

GASTRO-ENTEROLOGY—Bockus.

This report concerns itself with Volume II of the three volume set entitled Gastro-Enterology and covers the small intestine and large intestine and peritoneum. The subtitle "Diagnosis and Treatment of Disorders of the Small Intestine, Colon, Peritoneum, Mesentery and Omentum" is a fairly good indication of the scope of this book.

While reading and studying this volume the living image of the author kept intruding itself upon my consciousness; for to have seen and heard him is to be impressed. His is an exceptionally clear, orderly, and analytic mind. Tall, vigorous, handsomely gray haired but with a youthful complexion and demeanor, Dr. Bockus energizes a group the moment he walks in and allows his educated stentorian voice to pound on your gray matter. The book is, in a sense, very much like Dr. Bockus. Here a vast, complicated field is covered in an orderly and concise fashion. Thought follows thought and chapter follows chapter in strikingly sensible progression. And the physical "get-up" of the book is excellent. The illustrations are just that, the color plates are "true", and the reproductions of radiographs are beyond criticism. (Here a special nod to Dr. Finkelstein.) Even the print itself is better than I have seen.

As for the text itself, it would be difficult in a short review of a rather techinacl subject, to pick out special chapters for praise or criticism. My own personal orchid goes to the chapter on *Chronic Stenosing Regional Enteritis & Enterocolitis.* I should think that all surgeons would want to read it. I found particularly illuminating the inclusion of applied anatomy and physiology of the small and large intestine, and the omission of overmuch detail about vitamins and avitaminosis. In this connection one must state that Dr. Bockus in his wisdom must have used the pruning shears extensively by not allowing anything of a rambling, superfluous, repetitious, or debatable nature to find its way into the pages of his book. This great teacher, having surrounded himself with star assistants, each a specialist within a specialty and forming a cracker-jack team, has given them their head but has kept them to the subject at hand. This book is, therefore a monument to his teaching genius.

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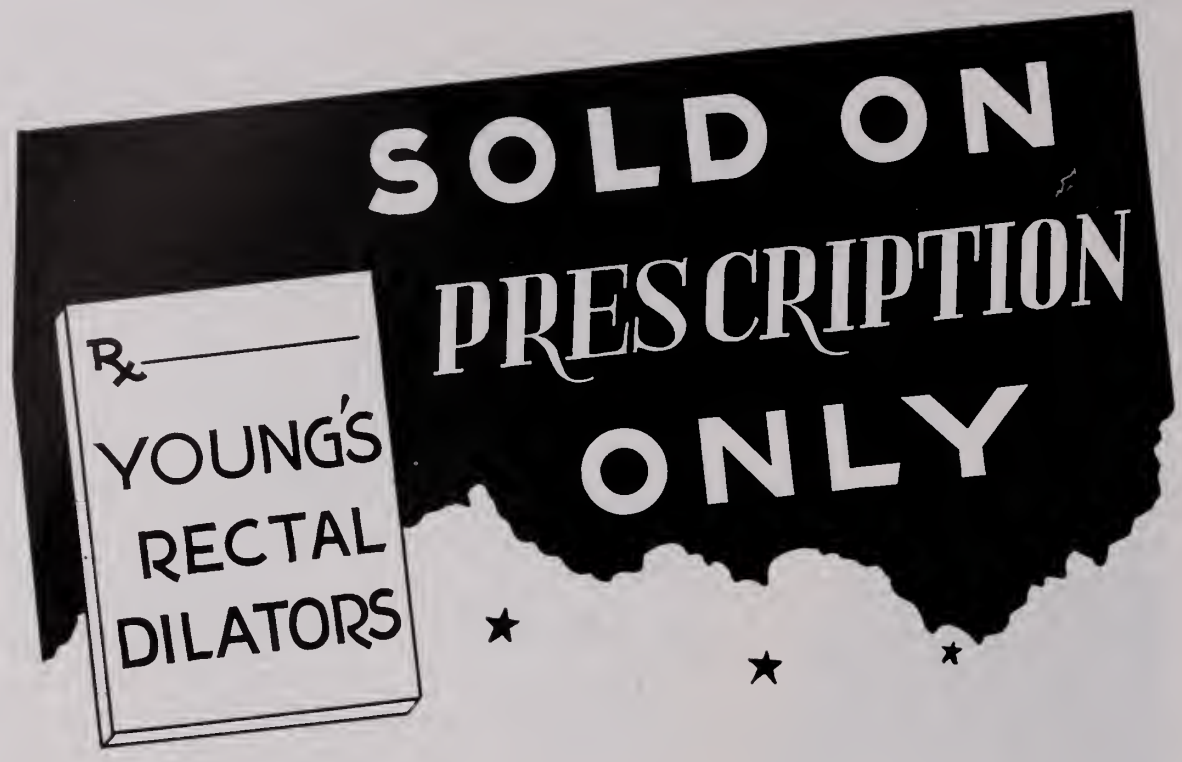
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PSYCHIATRIC NURSING

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must think and certainly psychiatrists and psychiatric nurses must "do". Anyone who has dealt with a disturbed overactive patient knows that the immediate problem, at least, cannot be solved by retreat to the study.

"Education is of the hand as well as of the head and heart." Mark Van Doren makes this statement in support of his thesis that a liberal education must be one to prepare the student for life, a thesis which warms the hearts of nurse educators. In nursing education discussions continually arise on the relative value of the technical skills—education of the hand—and the theoretical material—education of the head. In the words of another leader in education, "Any subject may be taught vocationally if it offers specialized training for professional work. On the other hand, the teaching is 'liberal' if the course material, though professionally useful, is treated so as to bring out its relation to the larger field of intellectual interest. Liberal teaching should stimulate curiosity and should lead to a critical examination of basic purposes."

The teaching of psychiatric nursing has always emphasized that nursing—all nursing—is the art of utilizing the head and heart and hand to comprehend and deal with the total picture of the patient and his needs. With this teaching psychiatric nursing makes its greatest contribution to nursing education.

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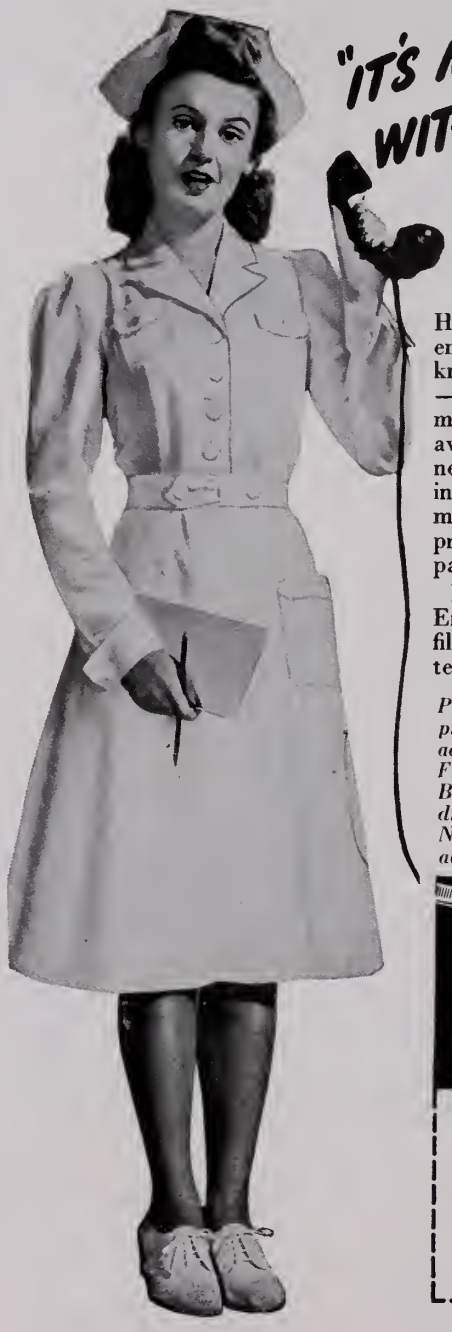
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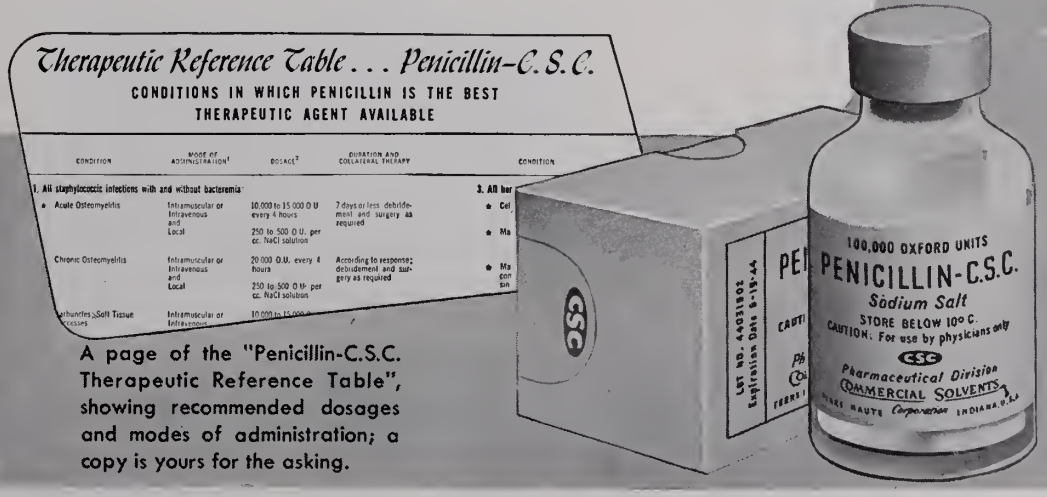
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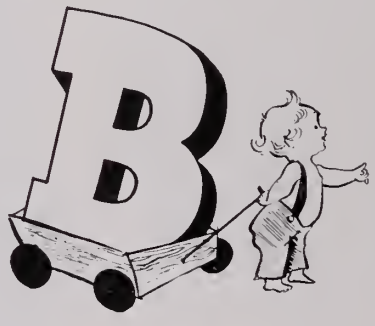
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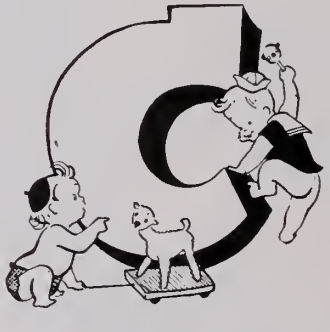
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Volume XXVII, No. 9

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[1] Clement, F. W.; Elder, C. K.: Anesthesialagy, 4:516, September, 1943.

[2] Forsee, J. H.; Shefts, L. M.; Burbank, B.; Fitzpatrick, L. J.; Burfard, T. H.: J. Lab. & Clin. Med., 28:418, January, 1943.

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVII SEPTEMBER, 1944 No. 9

VIRUS INFECTIONS*

PAUL C. COOK, M.D.

The Author. *Paul C. Cook, M.D., of Providence. Visiting Physician, Rhode Island Hospital.*

SOME sixty years ago Pasteur laid the foundations of bacteriology, and Koch originated and developed the methods of study still in use. As the field of infectious disease was explored, it was realized that there was a numerous group of infections caused by organisms that could not be detected by methods then available. The first step toward identification of any of this type of organism was made by Beijerinck, who found that the causative agent of a plant infection, the tobacco mosaic disease, would pass through a porcelain filter that excluded all bacteria. In 1900 Reed discovered the virus of yellow fever—the first virus pathogenic to man to be identified.

A definition of viruses is that they are micro-organisms—or pathogenic agencies—smaller than bacteria which can multiply only within the cells of a suitable host. Their study follows the same principles as that of bacteria, but their ultra-microscopic size and exclusive intracellular growth are complicating factors. It has been suggested that viruses are too small to contain all the essentials of independent existence, hence their intracellular habitat.

Viruses are widely distributed in nature, practically all forms of life being their hosts. Bacteria have their own forms, called bacteriophages—the eaters of bacteria. It has been hoped that these phages might be of therapeutic use, much as insect pests are sometimes controlled by the introduction of their parasites, but this hope has not been realized. Plant virus disease is of great economic importance. The tobacco mosaic virus has been identified by Stanley as a crystalline protein—a discovery of fundamental importance, as this virus apparently has both the nature of a living organism and of a pure chemical compound, and is a bridge between the living and the nonliving. Biological chemists appear to be finding that other viruses are proteins. The question is raised as to whether viruses are micro-organisms or enzymes—a question too deep for consideration here.

*An address delivered before the 133rd Annual Meeting of the Rhode Island Medical Society, at Providence, May 24, 1944.

All Animals Subject to Virus Infection

All animals—invertebrates and vertebrates alike—are subject to virus infection. All our domestic animals have their various forms—cow-pox, dog distemper, swine fever—a long list. The fact that viruses are widely distributed among animals is of more than academic interest. Many viruses are labile and adaptable organisms, and can on occasion cause disease in both animals and man. The use of laboratory animals in the study of human virus disease is an example. Swine influenza in our mid-west was unknown before the influenza pandemic of 1918-19, and its virus is so close antigenically to our influenza virus that one may well be an adapted form of the other. Blake of New Haven reported four cases of atypical pneumonia in a family whose eleven cats were having feline distemper. Rabies and psittacosis come readily to mind as viruses pathogenic to animal and human hosts, and there are numerous other examples. All about us animals harbor many forms of the extremely ubiquitous viruses, any of which might by mutation become adapted to life in man as a new host, and thus start a new disease. It is one of the underlying facts of epidemiology that an old virus disease is a relatively mild one, organism and host have established some sort of a balance—a symbiosis, or an armed truce—but a new disease is of unpredictable virulence. It may be of any severity. The familiar example is that of measles when first it invaded the virgin soil of the Pacific Islands. Man himself is subject to some thirty odd forms of virus infection, many of them rare, others all too common. They range in severity from ailments as trivial as warts and the common cold to those as severe as encephalitis and yellow fever. I should like to take up briefly a few of these virus diseases.

continued on next page

Herpes Labialis

The first is one of the least consequence, herpes labialis, but it has some interesting features. It has been extensively studied in Australia. The virus is found only in man, but has closely related forms in animals. Infection occurs in childhood as aphthous stomatitis or canker, and once the virus has gained entrance it persists in latent form in the epithelial cells of the lips—rarely in those of other parts of the body—for the rest of that person's life. It is constantly being re-activated by non-specific stimuli, which may be a respiratory infection, exposure to heat, cold, or sunlight. People then, are either susceptible or non-susceptible to herpes. The herpetics have an antibody titer that is kept constantly high by repeated re-activation, the non-herpetics are negative re-actors, and there is not the intermediate group of moderate reactions common in other virus diseases that are endemic. Children show no antibody until the initial canker infection, when it quickly develops in high titer. The virus is said to be a most efficient organism in that it infects 90% of possible hosts for 90% of their lives. This power of a virus to live, in a latent form, in its host cells for years may be important in solving other problems in infections.

Poliomyelitis

Poliomyelitis is a virus disease of much more importance than herpes. Like all other virus conditions, our knowledge of it has been gained only recently, since newer laboratory procedures have made virus study more practical. Prior to 1937 it was thought to be solely a neurotropic virus, and that its only entrance to the body was through the exposed olfactory nerve fibres, hence various efforts to immunize by applying irritants to the nasal mucosa in an effort to protect the nerves by scar tissue production. Since 1937 it has been known that the virus is commonly present in the intestinal tract as well as the pharynx, and occurs abundantly in raw sewage whenever the disease is prevalent. Infection probably occurs either by the pharynx or tonsils or the intestinal tract. Subclinical invasion is much more common than clinical paralysis. An important point is that this harmless invasion may be changed by something that activates it—as a gastro-intestinal upset, a sore throat or a tonsillectomy—to active clinical paralysis. Francis—one of the discoverers of influenza virus B—reported a striking example of this that occurred in Akron. Five children in one family had simultaneous tonsillectomies. Twelve days later all had polio and three of them died. Of eleven healthy children who were playmates, seven had the virus in the feces, while no adults who had been in contact showed it. Probably these children were healthy carriers till operative trauma permitted further invasion by the virus. From this it seems as if tonsillectomies might well be avoided when polio is present in a community.

Influenza Most Important

Influenza is the most important of the virus diseases. While it has a low mortality, its widespread prevalence and extreme contagiousness make one of its epidemics or pandemics a notable occurrence. There is no need of describing its clinical features, which are those of any acute respiratory infection. The explosive way in which it invades a community, the rapid spread rising to a sudden peak and then subsiding in a few weeks, is typical of an epidemic. This quick invasion and rapid subsidence is favored by its short incubation period of two days, its marked contagiousness, and its manner of spread by droplet infection. An attack is followed by a short but more or less solid immunity to the infecting virus and the epidemic is soon over as all the available susceptibles are infected, but secondary waves may arise. Etiologically two forms of the virus have been identified—Virus A, discovered by Smith, Laidlaw, and Andrewes by ferret innoculation in 1933, and virus B, found independently by Francis and Magill in 1940. Virus Y is the term used for all other as yet unidentified forms of the virus, much as when the types of pneumococci were first studied we had types 1, 2, 3, and 4, with type 4 being everything that was not 1, 2, or 3. These forms of the virus are clinically indistinguishable but serologically distinct. All three forms may occur in the same epidemic, so that immunity acquired against A early in the epidemic is useless against B a few weeks later, and neither of these infections is protective against a possible exposure to any of the Y strains. These different forms differ antigenically among themselves—that is, A will have many substrains, but they are all A's, their differences not being enough to put them outside the family into the B or Y groups. Perhaps these differences are due to the inherent labile nature of the virus, and represent mutations of the same strain rather than different fixed strains.

The virus invades only the epithelium of the respiratory tract, with probably a special affinity for that of the bronchiolae and its spread along the surface of the respiratory system is extremely rapid. There is marked desquamation of the ciliated

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SICK HEADACHES*

WALTER C. ALVAREZ, M.D.

The Author. *Walter C. Alvarez, M.D., of Rochester, Minnesota. Professor of Medicine, University of Minnesota (Mayo Foundation); Consultant in Division of Medicine, Mayo Clinic.*

I AM talking to you this afternoon about migraine because it is an important disease which causes much disability and suffering. Worse yet, it usually disables just those highly intelligent and gifted persons who could and should be doing much for their families and the world.

I am talking about this disease also because today it is so little understood; even in high places it is being poorly diagnosed and poorly treated. We physicians are still handing these patients a poor deal. To illustrate: one day while standing in the anteroom of an able teacher of medicine, waiting to see him, I could not help overhearing a lovely woman, who had just paid several hundred dollars for a complete overhauling, complaining to the cashier that she had received little for her money. The professor had told her that she had migraine, but that was obvious when she came in. The examination had shown no "cause" for it, and as to treatment, the doctor had said, "There is nothing much you can do about it! I know, because I am suffering with an attack right now!"

Feeling as he did, I couldn't help wondering why the professor had gone ahead to take the woman's money for so futile an overhauling. He should have known that one never finds the "cause" of migraine by any amount of searching through the body; he should have known that the cause is a hereditary predisposition, and that the attack is a sort of storm which takes place in an overly sensitive brain.

Personally, I have little desire to examine these patients, especially when they have already been through one or more good diagnostic clinics. I have never seen migraine permanently cured by any type of operation. After a laparotomy the headaches may disappear for a time, but the tendency to get them remains unchanged. Hence it distresses me to see that always when a migrainous woman comes in to consult me my assistant's first thought is to put her through the mill. Even if she brings films recently taken, showing a normal skull and a normally functioning gallbladder, the assistant promptly orders new ones made. And the patient encourages him to do this; even when she is only a poor stenographer who has come to the clinic on borrowed money she says, "Go ahead and get your own films if it will help any. I am so desperate I want to leave no stone unturned." Actually, I see no need in these cases for roentgenographing the head or the gallbladder or for sending the woman for a complete neurologic study. In these migrainous persons one rarely ever sees anything significantly wrong in the films of the head, and they do not have a brain tumor.

My feeling is that when, in a busy day, I have only so many minutes to give to a migrainous woman, I'd much rather use them in talking over her life problems and in showing her how to live more calmly and happily, than in making useless examinations; I'd like to give her a good return for her money, and this is the only way in which I am likely to do it. Unfortunately, modern medical tendencies and beliefs being what they are, the woman almost always prefers to spend her time and money on tests. She thinks tests are everything, and it never occurs to her that after forty years of constant association with the sick I should have learned much about them and their diseases, and perhaps enough so that I can make some diagnoses without tests!

These women (almost all of the patients are women) go to the gastro-enterologist because they are nauseated, or inclined to vomit. Because they vomit bile, they think the liver must be affected, but it isn't. When these patients become jaundiced or get cirrhosis of the liver they generally become *cured* of their headaches! Most would profit much more from seeing a psychiatrist, interested in the problems of the sane, than from seeing a gastro-enterologist. There is rarely anything organically wrong with the digestive tract, and what the woman needs is not a diet or an operation, but rather information on how to live so calmly that her brain will not get so on edge that the little explosion will take place.

Peculiar Temperament of Migrainous Patients

Since 1867 it has been known that the cause of migraine is a hereditary peculiarity of the brain.

continued on next page

* An address presented before the 113th Annual Meeting of the Rhode Island Medical Society, at Providence, May 24, 1944.

The stomach is upset secondarily, just as in the case of seasickness or in Ménière's syndrome. What has come to interest me most about this remarkable disease is that the women usually have a peculiar migrainous temperament. They are more alike than are most sisters, and their troubles are due to their unusual sensitiveness, their nervous tension, and their easy fatigability.

In many puzzling cases it is essential that the physician recognize the peculiar temperament because it is so helpful in making the diagnosis. Often, in a given case, if the attacks are atypical it will be hard to be sure of the existence of migraine, but when I learn that the patient is a typically migrainous person whose attacks are coming in a typically migrainous way, whenever she gets tired, or tense, or distressed over something, I have no more doubt. Then if I see the woman in an attack, with all the charm gone out of her eyes, and her face a picture of misery and dejection — I am still surer of the diagnosis.

The essential thing about these women is that they are usually above the average in intelligence and social charm. They are tense, quick in thought and movement, and idealistic. They like to get things done fast and done just so. They are perfectionists. Most are hypersensitive to sounds and lights and smells, and this brings them much suffering. They fatigue and wilt quickly under any strain or excitement. They can get so tense, even thinking of doing something, that they can get a headache before they get started. From girlhood on they tire so easily that it is hard for them to go out socially, or to travel, or to keep up with an energetic beau or husband. Very interesting and not generally known is the fact that they have bad days when, although without actual headache or nausea, they feel dull and half alive and perhaps utterly miserable. I often get a migrainous patient to admit that even if she were to be freed from her headaches she'd still be unable to do much in this world; she'd still be frail and often ailing.

Most of these women tend, I think, to be petite, full breasted, and with a nice figure. Many have a hard, myomatous uterus, which may account for the fact that many are infertile or have only one child. Some are constitutionally inadequate. Because of their great sense of responsibility and their good intelligence, they usually carry on their shoulders the cares and worries of the rest of the family, and this often leads to their undoing.

In the worst and most prostrating cases there is often a combination of migrainous inheritance derived from one ancestor, with a psychopathic inheritance derived from another. Then, with all the difficulties in adjustment to life, and perhaps some conflict between the two halves of a split personality, the patient will have two or three headaches a week. It is an axiom with me that whenever a woman is having three attacks of migraine a week, it means that she is either psychopathic or else she is overworking or worrying or fretting, or otherwise using her brain wrongly.

Another bad combination is that of the migrainous heredity with that of hypertension or perhaps of allergy. I am sure that migraine is not primarily an allergic disease, but sensitiveness to chocolate or some other food is often a trigger which can "spring the trap" and bring a spell. Many a woman will say that, after she discovered all the foods that could give her migraine, she went on having attacks whenever she worried, or menstruated, or took a journey or gave a dinner party, or had a bad night's sleep.

Because of their great need for good and kindly and considerate care, most migrainous women choose their husband principally for qualities of great kindness and gentleness and steadiness. As I often say to them, "You had to have an angel to put up with all your illnesses, and you got him." And usually he says, "I'm satisfied. I'd rather be married to a frail, sickly little woman who, when well, is a keen, delightful, and socially charming person, than to a strong, always healthy woman, with no special distinction or charm."

Typical and Atypical Attacks

As everyone knows, the typical attack of migraine begins with a scintillating scotoma which is present for about twenty minutes. This is followed by a throbbing, unilateral, usually frontal headache, with nausea, utter misery, and perhaps vomiting. This attack may last for from hours to several days. Sometimes the woman's husband will say that he can tell the night before that she is going to have an attack because of a certain facial appearance, an unusual degree of activity or loquaciousness, or a bad breath.

Actually there are many atypical forms of the disease. In my experience, the scintillating scotoma is usually lacking, and the patient does not know what I am asking about. The headache may be on both sides of the head, it may be nuchal, or it may be so mild that the patient does not complain about it. Similarly, there may be but little nausea and no vomiting. There may be only abdominal pain with vomiting, and then the patient may be operated on for a supposed intestinal obstruction, duodenal stasis, cholecystitis, or appendicitis. In these cases of atypical migraine the essential thing, as I said before, is to recognize a typically migrainous person who falls ill in a typically migrainous way after getting tense or tired or nervously upset. Sometimes I am pretty sure attacks are not due to a supposed cholecystitis when the vomiting lasts two or three days, in spite of the giving of morphine. This is too long for a gallstone colic.

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ANESTHESIA IN THE TROPICS*

CAPTAIN EDWARD DAMARJIAN, MC

The Author. *Captain Edward Damarjian, MC, of Providence. Assistant Physician, Rhode Island Hospital; Now stationed with a Hospital Unit in the China-Burma-India Theater.*

(Subsequent to the writing of the following paper by Dr. Damarjian we have been informed by him that the anesthesia department of his Unit has taken greater strides, and it now has its own Evacuation Hospital equipment available so that a very busy schedule is being carried forward with four gas-oxygen-ether machines working every morning and practically all afternoon. It is also reported by Dr. Damarjian that since this article was written the anesthesia department has found that Pentothal sodium for intravenous anesthesia can be stored in solution for quite some time (as long as three weeks) before administering it. This, the doctor relates, has facilitated the work, especially when battle casualties come in large numbers, and it has also permitted a considerable saving in the amount of Pentothal.—The Editors.)

THE purpose of this paper is to discuss the difficulties one encounters in attempting to administer anesthetics under unfavorable circumstances and with limited facilities.

The weather at first was hot and dry, the temperature on some days hovering around 118° F. with low Relative Humidity averaging 42% (Hygrometer calculation). The two months of rainy season added to the unfavorable climatic conditions with an average temperature of 80° F. and a Relative Humidity of 90% as compared to a New England summer average of 40%.

The anesthetic facilities were limited to the liberal use of open drop ether and chloroform, without any type of anesthesia apparatus. There was no suction apparatus. A limited supply of commercial oxygen was available. By an especially made attachment made by the Ordnance Dept. a reducer and regulator obtained from a B.L.B. oxygen mask was attached to the source of oxygen, thus making available oxygen, by means of its original B.L.B. mask or by catheter to supplement the inhalation anesthesia administered. No nitrous oxide or any other type of gas could be obtained.

A small supply of Procain crystals and liberal amount of British made Percain (hypobaric solution 1:1500) in ampules for Spinal anesthesia was available. For intravenous anesthesia there was Pentothal sodium and two British made anesthetics, Hexostab, and Cyclonal, both soluble Hexobarbitones. The latter two were short acting anesthetics made available in ampules of powder (.5 gm.) and sterile water (5 c.c.) ready to be mixed for use. In addition to these a personally owned laryngoscope with a single cuff type of endotracheal Catheter (No. 34 fiber) completed our supplies and equipment.

However, in spite of our limited facilities, a considerable number of operations were completed with a low mortality and postoperative morbidity. During a period of 8 months a total of 1,584 cases went to surgery of which 556 were done under local anesthesia. The remaining 1,028 cases were subdivided as follows:

Ether	
Open Drop	511 cases
Endotracheal	12 cases
Chloroform	208 cases
Spinals	
Procain	46 cases
Percain	225 cases
Intravenous	26 cases

In order to maintain an adequate personnel for such a large number of cases a group of nurses were trained to administer the inhalant anesthetics. In addition to this, various improvised methods were established with the aid of the Ordnance Dept., such that, most any type of case could be adequately handled. A suction method was devised which on many emergencies served its purpose. Another crudely made contraption served to administer endotracheal ether for maxillo-facial surgery or for time consuming spinal fusions which necessitated the patient being in the prone position. Sets of syringe, tubing and needle attachments were made for continuous administration of intravenous anesthesia by the anesthetist sitting at the head of the table, both as simple pentothal administration or in conjunction with a continuous intravenous saline infusion in prolonged cases, thus enabling a single person to give the anesthetic and administer the required oxygen. A back raising lift, made of wood, was devised for the continuous spinal anesthesia cases. These various appliances will be more fully described under their appropriate headings.

continued on next page

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Inhalation Anesthesia

In spite of previous warnings before coming to this climate about the difficulties that would be encountered in the administration of ether, this type of anesthesia still remains the one of choice. Chloroform was used for the short surgical procedures. Of course, it must be admitted that pouring ether in the tropics is decidedly different from that encountered at home in the States. With a room temperature well above that of the boiling point of ether (96° F.) it was soon learned that if the ether was kept on ice until just previous to the start of surgery, most of the evaporation was prevented. Empty rubber-stoppered plasma bottles with two double pointed needles which usually come with the plasma sets, inserted into the rubber stoppers, served as adequate ether containers. The adequate supply of artificial ice helped considerably to remedy this problem. Of more concern than the evaporation of ether was the condensation of the patient's breath on the gauze in the mask. The patient's exhaled air upon striking the cold ether mask would quickly saturate the gauze with water and make the vaporization of the agent too slow to be effective. Unless the gauze in the mask was changed occasionally for a fresh dry piece it was impossible to get the patient beyond the second stage of anesthesia. It was for this reason that more than the usual quantity of ether was required for induction and maintenance of anesthesia rather than the loss by evaporation as commonly believed. A cool storage place for the ether would be adequate if refrigeration is not available.

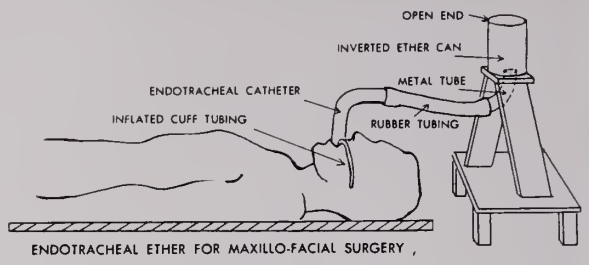
(a) *Endotracheal Ether*

For cases of maxillo-facial surgery or any surgery on the head where a clear operative site was required, and also for prolonged cases of spinal fusion in the prone position, a device was made to get the cone away from the field of operation. An endotracheal tube was inserted after induction and the end of the endotracheal tube was attached to another piece of metal tubing of sufficient diameter and this was in turn soldered to an inverted large ether can with its bottom removed. The ether can was cross-hatched with several strands of wire half way down. Thus, the ether can served as a cone with the wire mesh as a supporting shelf for the gauze to be saturated with ether. Satisfactory results were obtained by this method and there was no tendency towards any accumulation of carbon dioxide. (See Sketch 1.)

Spinal Anesthesia

Because of the limited supply of Procain crystals, a great majority of spinals were done with the British made Percain, a 1:1500 hypobaric solution re-

SKETCH 1

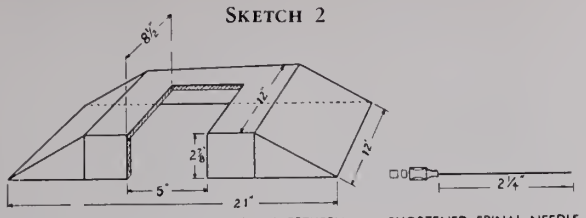


ENDOTRACHEAL ETHER FOR MAXILLO-FACIAL SURGERY ,

sembling Nupercain. This drug was supplied in 20 c.c. vials. Because of its prolonged action it was, in many cases, preferable to procain. Many of the patients treated were Chinese and a high incidence of recto-anal surgical conditions were noted among these soldiers. It was found that 6.5 c.c. of the Percain hypobaric solution was sufficient to produce a complete saddle anesthesia for these rectal cases, such that at times three of these rectal cases could be anesthetized from a single ampule of the drug. Contrary to the literature and to the circular of directions that was supplied with the drug, it was found that the desired level of anesthesia was obtained within 3 or 4 minutes, even in high abdominal cases, as compared to the 15 or 20 minutes suggested by the directions. The patient would then be immediately turned on his back with the head of the table lowered to the level position and prepared for surgery to last as long as 2½ to 3 hours. In spite of the frequently mentioned dangers of this drug, it proved to be relatively safe and effective spinal anesthetic as compared to the short acting Procain. With the latter, occasionally, a weighting solution of 10% glucose was added for high abdominal cases. Because of the larger volume of this weighting solution required, and the resulting irritation effect in the subarachnoid space, Percain was not similarly diluted.

A special back-lifting rest made of wood was constructed for continuous spinal anesthesia. This simply constructed apparatus was placed beneath the patient while he was lying on the operating table, with a sufficiently large aperture on the side and top of this lift to permit the manual adjustment of the spinal needle. Since no flexible, silver spinal needle was available, and also since most of the cases requiring this type of anesthesia were Chinese patients, who were generally of uniformly small frame, the average depth from the subarachnoid space to the surface of the skin was taken and a regular spinal needle was shortened and its point beveled. Thus, when in place, the hub of the spinal needle would be practically flush with the skin of the patient's back. As mentioned above the majority of these patients are of the same size and weight and one of these shortened spinal needles proved sufficient for all cases. (See Sketch 2.)

SKETCH 2



BACKLIFT FOR CONTINUOUS SPINAL ANAESTHESIA SHORTENED SPINAL NEEDLE

Caudal anesthesia for rectal cases gave sufficient relaxation but because of an occasional incomplete anesthesia and the length of time taken for anaesthesia to take effect, it was generally discouraged unless time permitted. A single unsatisfactory anesthesia can disrupt a busy operation schedule.

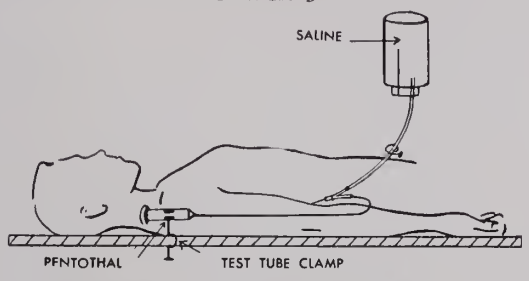
Intravenous Anesthesia

As previously mentioned the two British made intravenous anesthetics Hexostab and Cyclonal (Soluble hexobarbitones) were used for short acting anesthetics, and usually the entire contents of the respective ampule was required to produce the desired anesthetic effect, the drug action lasting only 4 or 5 minutes. For longer acting anesthesia Pentothal sodium was used. This was always given in a 2½% solution. By repeated practice such a solution could quickly be prepared dissolving the contents of the ampule of Pentothal powder in a one ounce glass filled practically to the brim with distilled water. Thus, 1 gram of powder in 40 c.c. of distilled water producing a 2½% solution. With the needle in situ, attached to 12 inches of a small caliber rubbing tubing, the syringe was now freely movable and usually attached by a test-tube clamp to the operating table or strapped to the patient's forearm, thus raising the level of the syringe above the height of the vein and preventing any small backflow of blood to clot in the hub of the needle.

It was soon found that far less pentothal was required if after the original required dose, additional 1 or 2 c.c. amounts be given only if the patient moved rather than depending on other signs of anesthesia. Also the additional doses were withheld until patient made relative gross movements as long as this did not interfere with the surgeon's work. A contraction of a finger or supination of a wrist sometimes would not be followed by any further movements of the patient for several more minutes in spite of the fact that the surgery continued. Morphia and atropine were routinely given preoperatively, intravenously, if time did not permit the subcutaneous route, and further supplemented by another dose of morphine later if the operation was sufficiently prolonged. Contrary to the belief of some authorities that morphine should not be given at all with intravenous pentothal because of their respiratory depressant action, it was decidedly proven that morphine helped to reduce the total amount of Pentothal required without any harmful effects.

A rule also was made to give oxygen routinely by B.L.B. mask if the anesthesia was to last over 10 minutes. In this way the postanesthetic recovery time was reduced to a minimum. If the operative time was to last over ½ hour, a continuous saline intravenous drip was first started and the Pentothal periodically added to the saline from a "Y" tube close to the intravenous needle. (See Sketch 3.)

SKETCH 3



Intravenous . . . Saline and Pentothal

Since pharyngeal reflexes are not usually abolished in Pentothal anesthesia, airways either by mouth or naso-pharynx were not used, to prevent any occurrences of hiccup, laryngospasm or vomiting. It was noted on eye cases that it was necessary to carry these patients somewhat deeper to prevent retching that may occur because of visceral afferent nerve fibers innervating these centers. If such conditions did occur it was customary to ask the surgeon to stop temporarily until the patient was taken into a deeper stage of anesthesia. However, if the surgeon continued to work the increase of intravenous medication would not readily abolish the reflexes, thus interfering with the required smoothness of such an operation.

Suction

Originally no kind of suction apparatus could be obtained for the hospital. It took our first and only anesthetic death to quickly devise some method of aspiration. An emergency case, a ruptured spleen, resulting from a kick from a horse, was given inhalation anesthesia. During his second stage of anesthesia the Chinese patient vomited several bowlfuls of rice, some of which he subsequently aspirated into his trachea. In spite of attempts to remove the column of rice from his glottis and trachea by means of a laryngoscope and forceps, the patient failed to recover from his asphyxia.

Within a few days a suction method was devised. A long piece of rubber tubing was attached to the intake manifold at the site of the windshield wiper connection on one of our hospital ambulances. The vehicle was parked close to the hospital window and with its motor running various amounts of suction could be obtained, sufficient for any type of need. The tubing was interrupted close to the patient by a flask to catch the overflow. (See Sketch 4.)

continued on page 491

The RHODE ISLAND MEDICAL JOURNAL

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MEDICAL CARE INSURANCE

It was heartening to read that some forty companies of the Health and Accident Underwriters Conference interested in medical care insurance met last month in Chicago. It was the expressed belief of those in attendance at this session that accident and health companies have a huge future field in medical care insurance similar to that now existing in the hospital insurance field.

Private insurance, necessarily cautious in new explorations of coverage, may well take a bolder advance towards the solution of any problem of distribution of the costs of medical care. The medical profession of this country has been most willing to assist private initiative in this field for it recognizes the trust that the people have placed in private insurance.

To meet what demand may exist medical societies in many parts of the country have undertaken the task of administering medical service plans, thus entering the field of insurance in competition with already established organizations.

The concerted effort of all these groups should prove a beneficial stimulus to the expansion of this type of protection for the employed worker and his dependents. Certainly the tremendous organizational and educational resources of private insurance may be utilized to great advantage at this time to develop enrollment in medical and surgical plans whether sponsored by medical societies or otherwise.

The latest report of the Hospital Service Plan Commission lists a total of 1,102,414 subscribers in the fourteen major medical-surgical programs now in operation, and of this number 194,289 represents the net growth for the first six months of this year. The actuarial experience being thus gained should set a pattern for future planning.

The efforts of these voluntary non-profit organizations may appear to some authorities to fall far short of the mark, as for example the small percentage so far enrolled in Massachusetts, where there are only 33,215 subscribers out of a total population of more than four million persons. However, a steady, progressive development is far more to be sought than a spectacular growth which would fail to remain constant.

Our course is yet to be set in Rhode Island. Certainly we are well into the exploratory stage. Perhaps the poll of public opinion being attempted this month with the distribution of card questionnaires to Blue Cross subscribers may give some inkling of what the man who is to pay the bill has to say about the question of pre-payment insurance for surgical and medical care.

THE NEW JOURNAL

Many changes have been effected in the Journal since its re-organization a year ago. The publication has doubled its size and its circulation. It has become the official publication also of the State Dental Society and the State Hospital Association, thereby establishing itself as the only state Journal in the country with complete professional coverage.

A tremendous amount of work has gone into the new Journal. Outstanding scientific articles, timely editorials, and informative departments call for much planning each month. In addition, the advertisements which add so much to the publication, both financially and as important reading material for the busy doctor, involve an increased amount of correspondence.

During the past twelve months the Journal has made rapid strides to advance among the top ranking state medical publications. Faced with increased operating costs that could not be met with the revenue from the advertising at the old rates, the Committee on Publications has authorized a new rate schedule for 1945 consistent with the increased value of the Journal. Our members too often fail to realize the importance of our advertising which makes possible the publication each month for every member at a minimum cost.

Most gratifying to the editorial staff in its labors has been the steady stream of correspondence from the members serving with the armed forces who find the Journal the vital link with their colleagues here at home. To these men, wherever they are in service, the Journal is sent each month. We do not know whether each issue gets through to each doctor in service, we can only hope that our efforts are successful in every instance.

How truly important the Journal has become to these men in foreign service is best illustrated in the words of one who wrote: "I can't tell you how much I enjoy receiving the Medical Journal, and I read it avidly. Even the advertisements I find interesting, for one gets a sort of nostalgic feeling when reading about local firms and seeing the names of well-remembered streets. The Journal has been a grand means for us fellows away from home to keep our fingers on the pulse of the community, as it were. Following the various transfers and promotions of friends has given me a great deal of pleasure. It sort of makes you feel that you are still one of the gang when you know where they are and what they are doing."

PHYSICAL FITNESS YEAR

A special emphasis year on physical fitness started this month. You didn't know about it? Well, that just goes to show that you have been working too hard and neglecting your golf these pleasant days. Of course, we will have to admit we ourselves are not quite sure what the objectives of the program are, but there is something esthetic about that expression "being physically fit". It reminds us of our college days when we went without garters, an undershirt or a hat on even the coldest of days.

According to our best advice the purpose of this special emphasis year on being fit is to arouse the public to its responsibilities for a stronger, healthier home front necessary for the pursuit of the war and for the peace that everyone says is going to follow. It all stems apparently from the findings of our doctors and dentists who found so many preventable and correctable defects among those examined for military service. The condition of the youth of the country is terrible, state the physical education experts. Of course we did find some six or seven million "flabby" GI Joes who are taking on the toughest killers in the world and running them to their corners, but think what they could do if they were physically fit!

NOW YOU KNOW

Since doctors are vitally concerned with the health of the people it is fitting that special attention be given to the proposals of the state political parties regarding health in their platforms.

The Republican State platform stated:

"A thorough study of the problems of the mentally defective and defective delinquent and the establishment of a program under the departments of Social Welfare and Education for their proper care and education to the end that they may become at least partially self-supporting.

"Strict and vigilant adherence to the standards of our laws governing the right to practice the healing arts and vigorous prosecution of those persons who violate their provisions."

The Democratic State platform stated:

"Recently a Health Council was appointed to examine into the health facilities of this State with a view among other objectives of making general hospitalization available to all our people. We believe it to be a proper function of the governments to sponsor and develop a health program for their people. We commend Governor McGrath for making Rhode Island a leader in this respect."

Now you know what to expect when you go to the polls to cast your ballot in November. Or do you know?

ANNUAL ROSTER

It is planned for the October Journal to carry the annual membership roster of the Rhode Island Medical Society. The roster will include only the names of members in good standing, therefore any doctor in arrears in the payment of dues should clear his indebtedness if he desires to be listed.

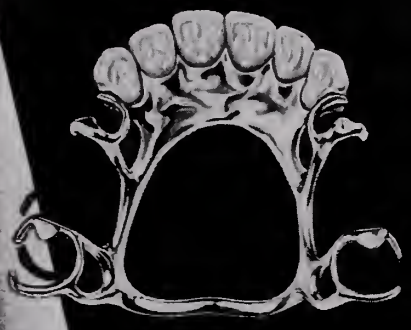
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A SURGICAL PROCEDURE FOR THE CORRECTION OF AN ALVEOLAR DEFORMITY

HENRY HELFAND, D.M.D., of Woonsocket, R. I.

This is a case of osteoplastic surgery of the upper alveolus for the correction of a deformity induced by a bad tongue habit of pressure against the upper anterior teeth and a thumb sucking habit carried on during childhood.

The entire pre-maxilla and the teeth contained within were forced in a plane of protrusion to such an extent that when calcification took place the over-bite of the upper incisors beyond the lower measured approximately 20 m.m. (See Fig. 1.)

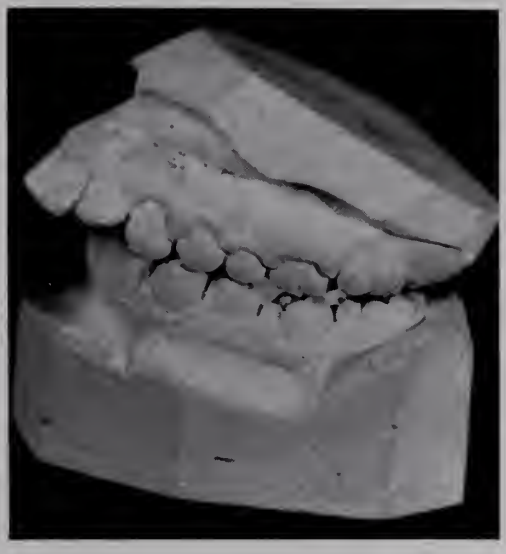


FIG. 1

All other teeth are well formed and remarkably free from caries, although the upper incisors give the appearance of being too large. (See Figs. 2 and 2a.) The upper arch has a typical V shaped appearance showing constriction at the bicuspid-molar region on both sides. The mandibular arch by contrast appears in a retrusive position. (See Fig. 1.)



FIG. 2 FIG. 2a

The question of referring this patient for orthodontic treatment was considered and suggested, but due to her age (21), the time necessary for the completion of this work and the unwillingness on her part to undergo orthodontic correction, it was deemed advisable to resort to a surgical procedure for the correction of this deformity.

At this time I should like to mention that the appearance of the patient contributed a great deal to her mental distress. This was an important consideration for she had become depressed, introverted, and limited her social activities only to a few close friends.

Surgical Procedure

Under local novocaine anaesthesia, blocking off the area from the upper bicuspids to the corresponding bicuspids, a vertical incision was made starting at the reflecture of the mucous membrane and cheek and continuing downward to the gingival margin overlying the upper second bicuspid on either side of the jaw. The muco-periosteum over-

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PROVIDENCE

SURGICAL PROCEDURE FOR CORRECTION OF ALVEOLAR DEFORMITY

continued from page 459

lying the teeth between these vertical incisions was then stripped back exposing the buccal alveolus. With mallet and chisel the outer cortical plate of bone was removed exposing the roots of the teeth. The eight anterior teeth were removed and the interseptal bone was cut away with rongeurs. The sharp edges were smoothed with a bone file. The palatal tissue was then retracted and the vertical dimension was shortened about 4 m.m. Care was taken to leave undisturbed the incisive foramen. All bone spicules were removed, the area washed with a warm saline solution and tincture metaphen applied to the exposed surfaces. The edges of the gum flaps were approximated and excess soft tissue trimmed. Sutures were placed at intervals without too much tension to prevent the wound from opening. No dressing was inserted.

Home Treatment

Application of an ice-bag to outside of face for one hour and repeated at intervals during the day to control swelling. For relief of pain codeine sulfate gr. ½ with empirin gr. 5. On the following day hot intra-oral irrigations every two hours and the application of hot magnesium sulfate packs to face was prescribed. Recovery was uneventful and the sutures were removed on the fifth post-operative day.

Impressions were taken a short time later for a prosthetic replacement and a temporary acrylic partial plate constructed. Figs. 3 and 3A show partial plate in mouth, resulting in more pleasing and normal relationship. Figs. 4 and 4A corresponding models.



FIG. 3



FIG. 3a

Summary

Many cases of facial defects having their origin in malformation of the dental arches are amenable to corrective measures. Age, mental attitude and the time element are some factors which must be considered in the management of such dental deformities. Routinely, many cases of oral surgery can be carried out in the office, but it is well to remember that where the surgery may be prolonged and the patient is not too co-operative, it may be best managed at the hospital. The choice of anaesthesia should always be left to the discretion of the operator rather than to the patient. Post-operative care is of the utmost importance in the prevention of complications and the necessity for thorough and careful treatment cannot be stressed too strongly.



FIG. 4



FIG. 4a

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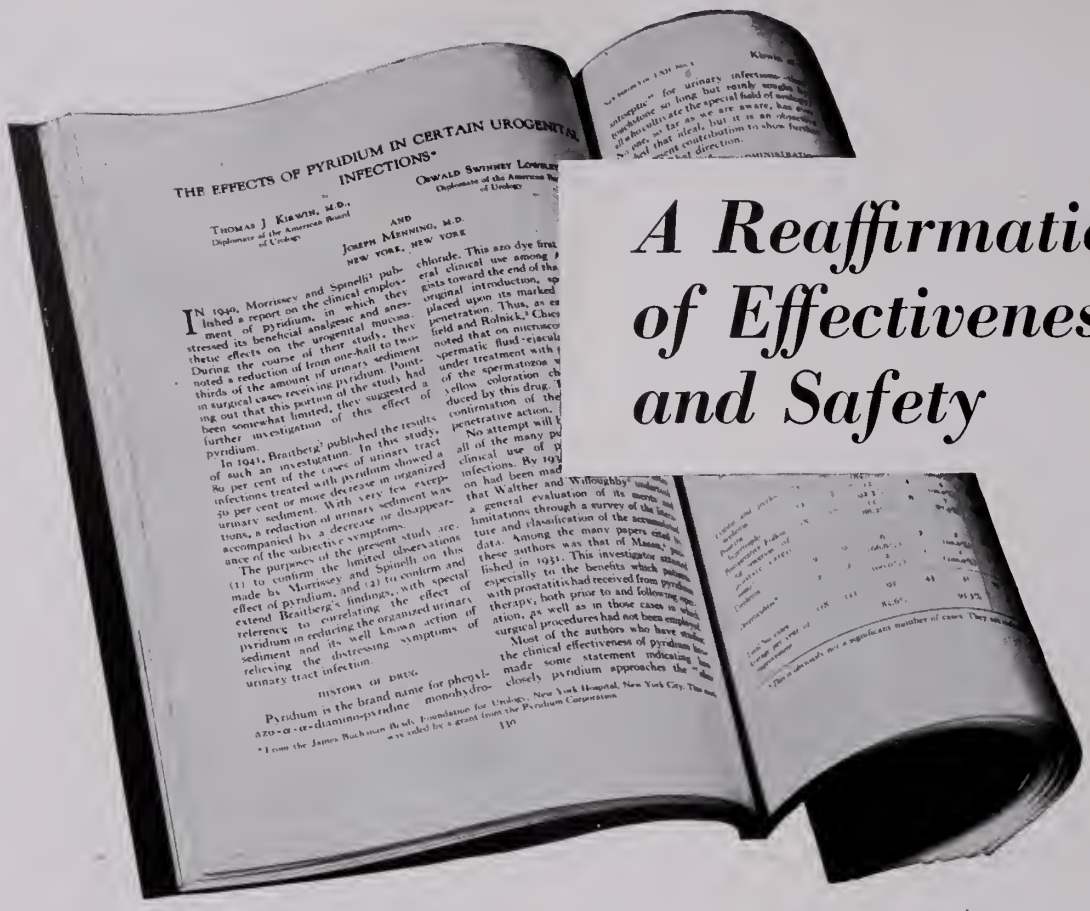
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A Reaffirmation of Effectiveness and Safety

THE recent careful study conducted by Kirwin, Lowsley, and Menning, of the James Buchanan Brady Foundation for Urology, New York Hospital, and published in the December 1943 issue of *The American Journal of Surgery*, reaffirms the many previously published reports emphasizing the clinical effectiveness and complete safety of Pyridium in the symptomatic treatment of common urogenital infections.

In this study of 118 cases of common urogenital infections, routine Pyridium therapy administered for a period of two weeks produced relief of the distressing symptoms in the following percentage of cases: Pain on urination was alleviated or abolished in 95.3 per cent of the cases; burning on urination was relieved in 93.6 per cent of the cases; frequency was greatly reduced or abolished in 85 per cent of the cases; and nocturia was reduced or eliminated in 83.7 per cent of the cases.

The prompt and effective symptomatic relief provided by Pyridium is extremely gratifying to the patient suffering with distressing urinary symptoms. Gratifying also is the confidence in the physician and his therapy which is so evident among patients who are treated with Pyridium.



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VIRUS INFECTIONS

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epithelium and proliferation of the underlying connective tissue. The spread is entirely a surface one, the virus never being found in the blood. Only rarely is there pulmonary consolidation, this is usually the work of secondary bacterial invaders when it occurs.

Epidemiologically there are three forms of influenza — sporadic, epidemic, and pandemic, There has been no pandemic since the discovery of the virus, so there is no information about this type although it is presumably caused by one of the known viral forms. Also, little is known of sporadic or endemic influenza. Clinically it is the same as the epidemic variety, but the etiology is unknown, although there is evidence that it is not caused by virus A or B. In sporadic influenza secondary infection of the respiratory tract, particularly of the paranasal sinuses, is common. Epidemic influenza, then, is the only form of which we have definite knowledge of the etiology.

Attempts at therapy have so far been symptomatic only. Chemo-therapy has not as yet been effective against any virus disease, but then, no one has as yet tried very hard to make it so, and there may still be important advances along this line. Specific anti-sera have not been of any therapeutic use. Prophylaxis is at present unsatisfactory. Injected vaccines have had only moderate success, as might be expected in a disease that is local, in the respiratory epithelium, and not systemic, that is caused by several different organisms, and one that does not itself confer a good immunity. Intranasal innoculations with attenuated virus, and inhalations of aerosols—suspensions of vaccines or anti-sera in air—apparently have shown some promise.

Frequency of Change Noticeable

As a group, virus diseases are more subject to change than other types of infection. New or newly recognized diseases have appeared in recent years, several of which affect the central nervous system. In 1917 encephalitis lethargica was first noted, unrecognized forms of which are suspected of being the cause of much of our Parkinson's disease. In 1933 and thereabouts there were outbreaks of other types of encephalitis, notably the St. Louis and the equine types, both probably from animal hosts. Neither of these have become common human infections, although they are still occasionally met with. Psittacosis was more successful. It got good publicity in 1933 when cases developed from infected parrots, and has been with us since to perhaps an unrecognized degree. Heilman and Herrell, of the Mayo Clinic, have recently reviewed the subject, and say that probably a third of our so-called virus pneumonias are due to this virus, which, because of its wide distribution in many species of birds, should be called ornithosis rather than psittacosis. Transmission of the disease is now commonly from man to man rather than from bird to man, an evidence that the virus is fairly well established in its new host.

Poliomyelitis, again, is a disease undergoing change. Only since the end of the last century has it developed virulence enough to cause epidemics which are increasing in severity and frequency in certain countires—Sweden, England and the United States. The age incidence has also advanced from infancy to school age or even higher, a change unusual in a disease which is becoming more frequent. As an infection becomes more widespread one would expect a lower age incidence, as opportunities for exposure multiply. Perhaps the answer is that the disease is increasing in countries with a high standard of living, and that comparatively good hygiene prevents widespread infection of infants. As subclinical infection with nonparalytic strains at an early age is the means by which immunity is developed, better hygiene in this case means more susceptible school children, and more clinical disease among them, their usual communal attitude to toys, pencils and lollypops favoring the spread. Small pox has changed its nature, and is a far milder disease than the virulent infection that killed more children in Europe in the 18th century than all other contagious diseases combined. This change is not due to Jenner's vaccination, which has reduced tremendously the incidence of the disease, but has not altered its virulence.

continued on page 465

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VIRUS INFECTIONS

continued from page 463

A most striking change in the character of a disease marked the influenza pandemic of 1918-19, when a sickness that had always been noted for its mildness suddenly took on added virulence to go with its extreme invasiveness. The mortality was above that of any previous outbreak, there being over twenty million deaths throughout the world, over five-hundred and forty-eight thousand in this country alone, with the number of cases fifty times as great. What really marked the pandemic as a changed disease was the age incidence. The extremes of life, the infants and the aged, from whose ranks had before come the few fatalities of influenza, were comparatively immune, and the brunt of the attack fell on young adults. This age distribution prevailed in all countries in all waves of the outbreak. Epidemiologically this is the sign of a new disease. There has been no exposure at an early age, no development of immunity or succumbing to it, and a generation of young adults with complete susceptibility results. It is the story of the reaction of the Polynesians to measles all over again. We now know that there are different strains of influenza virus, capable of marked variation From somewhere there was brought to crowded war-time Europe a strain so different antigenically that a new disease resulted. Possibly the change in the nature of the virus was such that it paved the way for secondary bacterial invasion to a greater extent than usual. These intercurrent infections with different organisms were numerous and the major cause of mortality. As this was before the recognition of the influenza virus, the bacteria were commonly regarded as the cause of the disease. If we ever have another pandemic with similar tendency to secondary invasion we may well be thankful for the sulfonamides, pencillin and whatever new weapons the chemists may have given us by that time. Perhaps there will be a sulfonamide derivative that will attack the virus directly before there is time for this secondary invasion.

Possibility of New Virus Infections

What the future has in store for us in the way of new virus infections is something no one knows. There are many viruses all around us, living in harmony with their animal hosts, and doubtless some of them will in the future invade us, and either adapt themselves to their new habitat and establish new diseases, or fail to adapt fully enough to maintain their foothold and so die out. We should hope that any successful colonization of ourselves by the viruses will be by some amiable strain of mild severity. An Australian student of viruses, Burnett, has said: "Few things might have greater consequence to humanity than the evolution of a new virus with the spreading power of influenza and the virulence of old-type smallpox."

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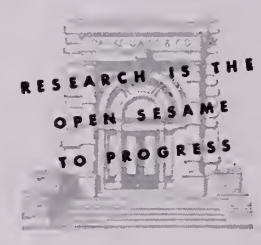
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SICK HEADACHES

continued from page 452

Often a physician will be puzzled unless he draws out the fact that the woman has two or three different types of headache. Once this is recognized and the history is straightened out and untangled, the diagnosis may become clear.

Another very helpful diagnostic point is that when the woman was a girl in high school, she used sometimes to be sent home with an attack of so-called bilious vomiting. Such vomiting is often a forerunner of migraine. Another diagnostic help is the discovery that one or more near relatives of the patient have typical migraine. A fact that can almost clinch the diagnosis is that during the woman's pregnancies she was well. Clinching, also, is the fact that an intramuscular injection of gynergen will block or put a stop to an attack.

Treatment

The treatment of migraine falls into two divisions: one, that of keeping the attacks from coming and, two, that of aborting them when they start

I know of only one drug that is likely to cut down on the frequency of the spells and that is sodium or potassium thiocyanate. Unfortunately there is a little danger attendant on the use of this substance: it can injure the blood, and it has caused venous thrombosis. I use it only when the patient is having many attacks a month and will not or cannot control the situation by living more calmly and sensibly. It is particularly likely to help also if the patient suffers from hypertension.

Curiously, phenobarbital and dilantin, which help so much in holding down the number of attacks in cases of epilepsy, do not seem to affect the triggers which start attacks of migraine. I haven't seen good results from treatment with ovarian or pituitary hormones or vitamins.

It is well, if possible, to get the migrainous woman to see that she will probably always have the tendency to the disease; that she'll always be overly sensitive and easily fatigued, and hence she might as well stop her search for a complete cure. If she is lucky and if she lives sensibly the headaches should grow less severe with advancing age. They may disappear after the menopause, but she cannot count on that.

The best way in which to get rid of migraine is to solve life's problems and to learn to live calmly and peacefully, and free from conflict with self and others. In many cases the exciting cause of the attacks is marital infelicity and much thinking about divorce. In some of these cases I almost cure the disease by getting the woman to see clearly that she isn't tough enough or heartless or unkind enough to go ahead and get the divorce she craves. Then when she stops thinking about it she stops having headaches and gets as well as she can ever be.

I often think of the nice old bishop who knew more about migraine than did a number of internists, who, one after the other, had overhauled him, hunting for the "cause" of his headaches. As he said, when he was a poor divinity student working his way through college, and later when he was a young minister struggling up the ladder to success, he had one bad headache after another. But when success came, with an easy charge, and an assistant to help him, he had peace, and for years, no headaches. Then the Church made him a bishop and transferred him to a large city, and there, what with the endless cares of raising money, attending conferences, and pouring oil on troubled waters, his old curse came back to strike him down again and again. As he said, "If only I could get back to my easy church and my quiet garden, I'd be well."

As I often say to a tired migrainous woman, "If you had only used the money you spent on many futile medical overhaulings on getting yourself a good maid, you would have been well. A good maid is far more likely to cure you than I am!" Today, maids are beyond the reach of many; but many can help themselves greatly by avoiding conflicts and emotional storms, by being a less fussy housekeeper, by getting a nap every day, by going to bed earlier, and by cutting down, at least for a time, on a lot of unnecessary activities outside the home. In many cases the husband could almost cure the woman by giving up disturbing vices such as gambling or drinking or "chasing," which keep her upset, or by, in other ways, making life much happier and easier for her.

Often it helps a bit to combat constipation, perhaps with enemas of physiologic saline solution. Rarely it helps to get good glasses and to correct any imbalance in the external muscles of the eyes.

Gynergen or ergotamine should not be taken daily to *prevent* attacks. This would probably be dangerous.

In trying to *abort an attack* an essential point is to begin quickly. Once a patient is nauseated and badly depressed it is useless to put medicine into the stomach: it will not be absorbed. After this stage is reached all medicine must be injected either into the muscles or into the rectum.

The best drug with which to abort an attack of migraine is ergotamine tartrate or gynergen. Many physicians fear it, but I do not, because in twenty-five years I have never seen it do any serious harm, even when taken as often as three times a week. In some cases the breathing of pure oxygen for an hour or two works perfectly. Morphine should not be used as it works poorly, and is too dangerous a drug.

continued on page 498

The Good News is . . .

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As recommended by many Rhode Island physicians, Blue Cross now extends protection to Self-employed, unemployed, retired, or other persons employed in establishments having five or less employees. Opportunity for this new individual enrollment is *open to October 18th only.*

This new, widespread Blue Cross service, bringing the important protection of prepaid hospital service to the vast majority of Rhode Island citizens, will undoubtedly have your active support through recommendation to all eligible people within your sphere of professional and social contacts.

Farmers, fishermen, domestic employees, professional people, small business men—are among those who may now join. The age limit is 65 years and the usual Blue Cross health statement is required. The waiting period for maternity cases will remain at 9 months.

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OVER 200,000 VOLUNTEERS . . . .

The Story of Blue Cross in Rhode Island

DENNETT L. RICHARDSON, M.D.

A sharp autumn rain beat against the window. Inside the downtown office building, seated around a table in a sparsely furnished room, sat several of Rhode Island's leading business and professional men who had indicated an interest in a new and basically simple plan which would provide for prepaid hospital care on a voluntary basis.

A thorough discussion of the merits of various proposals to provide financial help for the one family in five which is hospitalized each year was in full swing and the minutes winged into hours. At one end of the table a man coughed, hesitated, and then signalled for attention. Obtaining the silence he sought, he rose to his feet and stated simply: "Gentlemen, the hour is late. There is yet much to discuss, but I propose we adjourn and meet again to further these plans. However, we would all do well to take this thought with us. This is to be a non-profit organization, formed solely to render a service to the citizens of Rhode Island. I hope that we incorporators may leave a stamp of liberalism upon the charter which will allow for just as complete a plan of prepaid hospital care as is consistent with the economic security of Blue Cross".

Thus was sounded the keynote which would guide the payment of thousands of hospital claims which would subsequently be established.

These discussions took place in 1939. The first legislative act that the then Governor William H. Vanderbilt signed was the "Enabling Act" which granted the privilege of forming the Hospital Service Corporation in Rhode Island. After incorporation came the election of officers, the appointment of an Executive Director, and — particularly important — the drawing up of contracts with the hospitals and with the public. Many meetings were held to iron out these policies and the Rhode Island Medical Society was asked for tentative approval of all contracts before their submission to the Board of Directors and to the Department of Business Regulation. On September 1, 1939 the first contracts with the public became effective and at the end of the year — after a four months enrollment campaign — 7,896 Rhode Island citizens had become subscribers to the Plan.

Today the total membership in this State is over 210,000 members.

In between is the story of a non-profit organization, formed to serve the public, meeting with general acceptance because it rendered that service well, while offering sound financial assistance in the prepayment of hospital care.

The Blue Cross idea, which encompasses some 80 recognized plans in the country, was originated in 1929 at Baylor University where fifteen hundred school teachers paid $3 quarterly in return for guaranteed hospitalization when and if needed. A Dallas bank, learning about the plan, saw its soundness and worth and enrolled its employees.

continued on page 492

HOSPITALS AND THE SALVAGE DRIVE

The Editor, as a member of the Rhode Island State Salvage Committee, urges all hospital administrators to make a concerted effort within the next few weeks to contribute their institution's waste paper to the Salvage drive now going on.

Hospital personnel are urged to make an examination of storage places in the basements and attics for old account books, records and files that are no longer of value to hospitals, together with any other general waste paper that is routinely gathered, in order that this may be properly channeled through the State Salvage Committee.

Hospitals should contact Mr. Louis F. Adams, executive secretary of the Salvage Department, WPB, 530 Industrial Trust Building, for collection. Cooperation of all Rhode Island hospitals is urgently asked.

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(Sulman, L. D., 1943; Silcox, L. E. and Schenck, H. P., 1942.)

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WATSON, E. R.: SYMPOSIUM ON NUTRITION,
J. MED. ASSN. GEORGIA, 32:326 (Oct.) 1943



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CLEANLINESS IN INDUSTRY

A great many plants in Rhode Island are old—so old that they are still using antiquated plumbing facilities, washrooms and toilets, which should be modernized. The war has brought many changes. The introduction of women in industry has necessitated rearrangement of rest-rooms, and additional toilets and washroom facilities in many plants. While management was doing the job for the newer women employees it likewise modernized a good deal of its toilet facilities for the men. There are, however, still some and probably too many examples of insufficient toilet and washroom facilities.

The health directors of the plant, the physician who does industrial work only occasionally, or the on-call type of physician, has the responsibility to check on the facilities for bathing and showers in the plant and to give management advice regarding them.

The dusty, dirty occupations, particularly during the hot weather months, impair the efficiency of the employees unless they have an opportunity to take showers and have a frequent change of fresh uniforms. Industrial physicians should bear in mind that even though the man's occupation is a dirty one, and that he has been advised to take frequent baths, he is loathe to do so when he gets home for many reasons. One may be that he has no hot water and he has to heat it in small kettles which is a slow and cumbersome process, or he may have no bath tub. A great many of our industrial employees do not live in homes that are endowed with all the modern facilities and many an employee comes to work in the morning as dirty as he left the night before.

Showers established in the plant and utilized by the employees with permission of the management, twenty minutes before closing time, would do a great deal to cut down a good deal of skin irritation and also prevent skin infection as well as improve the general health, the morale, and efficiency of the employee.

There are plenty of posters and folders for distribution to workers, particularly women, that are available. Some of them are listed below:

"Jennie on the Job": This is a series of colorful posters prepared and distributed by the United States Public Health Service covering clothing, sufficient sleep, recreation, safety, posture and washroom tidiness. "Jennie on the Job" posters are obtainable from the United States Government Printing Office, Washington, D. C., for twenty-five cents a set.

"Health Problems in Industry": This is a pamphlet by Dr. C. O. Sappington, editor of "Industrial Medicine", and is a summary of information gathered thru visits to fourteen communities where there is a large employment of women. The pamphlet gives a detailed report of the problems and how we can meet them.

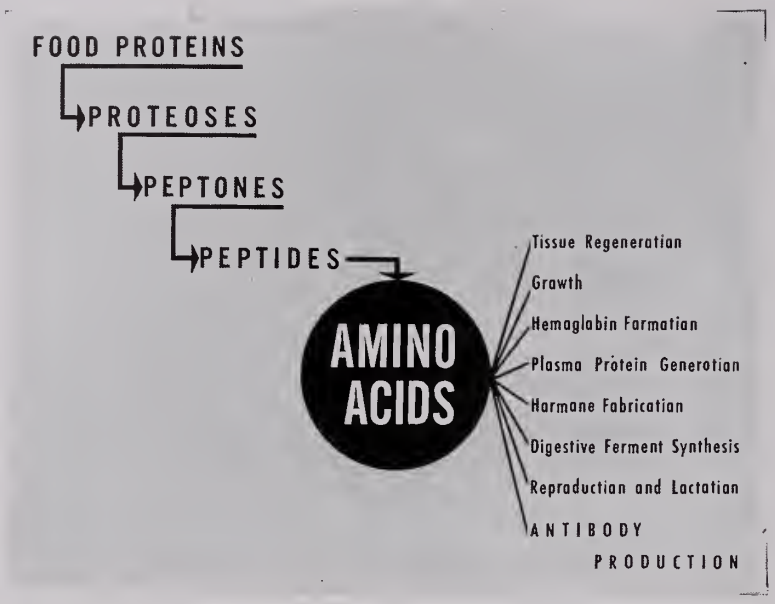
"Women on the Job": This is a folder for distribution to women workers in industry. It is prepared and distributed by the Metropolitan Life Insurance Co., New York 10, New York. Single copies in quantities are supplied free on request to the Company.

"Save Your Skin": This is an eight paged leaflet prepared by the United States Public Health Service. Single copies are five cents and are obtained from the United States Printing Office, Washington, D. C.

The Division of Industrial Hygiene, New Hampshire State Board of Health, Concord, New Hampshire, is distributing a poster for washroom, locker room use. It has an arresting caption in red lettering"Beat The Skin Game". Simple directions are outlined in four easily remembered steps.

There are many other articles, posters, pamphlets, etc., for distribution to employees and for posting on bulletin boards. An inquiry directed to the Librarian, Rhode Island Medical Society, will elicit information regarding many more of these publications.

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*"It is evident, therefore, that antibody production is but a phase of protein metabolism and that a protein deficiency, whether due to an inadequate protein intake, to protein loss, or to defective protein metabolism, must, in time, impair the maturation or preservation of the antibody mechanism. . . . This means, in turn, that food may play a decisive part in infectious processes in which antibody fabrication is desirable." Cannon, Paul R.: Protein Metabolism and Acquired Immunity, J. Am. Dietet. A. 20:77 (Feb.)1944.

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DOCTORS AT WAR

THE JOURNAL IN CHINA

We have recently received word from Captain Louis D. Lippitt that the April issue of the Medical Journal reached him in the China corner of the CBI theater of operations on July 31, and in spite of the long delay in its arrival it was a most welcome piece of mail for it meant a close tie with these Plantations.

Dr. Lippitt reports that "for some reason I am located in one of the more favorable areas, climatically anyhow. We have rain, but little of the humidity experienced in India." Taking care of air force service troops has its problems, according to Dr. Lippitt, but "our spot here is a bit like a grandstand—much passes before our eyes that gives more and more hope."

Non-military activities engaged in by our representative in the Far Eastern war theater include experience eating with chopsticks (of necessity a few times) riding in rickshas, and sailing in a sampan. However, "travel any distance away from the military area is over roads not meant for motor vehicles. The Army jeep stands up well but the upholstering was cut to the irreducible minimum so you can be sure I do not pleasure drive," the doctor reported.

AVOIDING THE HEAT WAVES IN ICELAND

Just at the time when many of our visitors were expressing the wish that they might be in Iceland to escape the record breaking heat wave that smothered this area last month we received a breath of cool air from the northern outpost in the form of a V-mail from our Captain Clarence J. Riley who holds the honor of being awarded an Air Medal for valor in the line of duty. Dr. Riley has recently been appointed Battalion Surgeon over the medical department of his outfit and as a result is kept busy. He reports that Dr. Frank Phillips, dentist from here who is in Navy service, manages to meet with him every week to enjoy a good meal and to discuss plans for the day when they will resume their practices in Rhode Island.

WITH THE INVASION FORCES

One of the first of our members to report of participation in the historic D-Day invasion was Lieut. Alphonse R. Cardi who has had "quite a time playing with life and death" since he landed with the 29th Division to open the Normandy beachhead. Dr. Cardi reports that "I thought I saw everything until I saw St. Lo. No city could possibly be any more rubble-ized than St. Lo. There was not a sign of an organized or constructed piece of material left to it and as I looked around from its center I trembled. It gets worse with each city we take."

Word was received by the family of Lieut. Raymond Luft of Warwick late last month that the Doctor was seriously ill in an Army hospital abroad. He participated in the invasion in which he served board a United States ship which carried men to the beachhead in France and returned to England with casualties. Subsequently he suffered a coronary occlusion while serving as medical officer on a transport and was transferred to an Army hospital.

Sometime ago we received letters from Major E. J. Bernasconi and Captain Robert L. Farrell from England, and we are now wondering if both were in on the D-day invasion. Major Bernasconi saw two years of service in Puerto Rico and Trinidad before being assigned as chief of the EENT department with a general hospital which arrived in Great Britain some months ago.

Captain Farrell gave us an interesting report of his activities since his enlistment and his indoctrination training at Carlisle. In March, 1933, he was promoted to Captain and shortly thereafter was sent out on cadre to help form the 63rd Infantry Division. Subsequently he was transferred to a Medical Clearing Company which was

continued on next page

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DOCTORS AT WAR

continued from preceding page

shipped overseas. His letter, written four days prior to D-Day, stated "at present I find myself in England anxiously awaiting the day when the curtain will go up on the big show."

ON THE TRAIL OF THE JAPS

From New Guinea where he has been stationed for sometime, Major Laurence A. Mori writes that "medical literature is scanty" and in answer to his plea we are speeding copies of our Journal, and also by his special request the July issue of the Archives of Internal Medicine.

From Lieut. (jg) William H. Tully we received a new APO so that "I may get the Journal direct rather than have it chase me all over the Pacific". As junior medical officer with a Naval Construction Battalion Dr. Tully is in a forward area, but he reports that "things are pretty well cleaned up here now so that we can come and go as we please without too much danger." He reports seeing our Lieut. Fred Riley at a Pacific base prior to leaving for the new assignment.

From Comdr. William P. Davis comes word that he is temporarily stationed in San Francisco, awaiting assignment in the Pacific area. We have sent Dr. Davis a list of the men, with their military addresses, who are in the Pacific theater in the hope that he may check up on some of them in his future travels.

MILITARY ANNOUNCEMENTS

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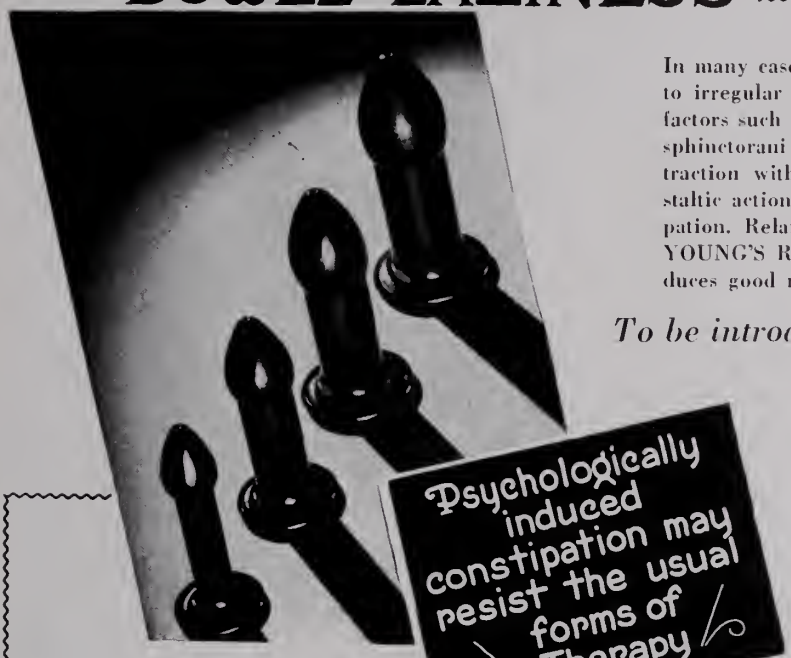
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"BOWEL LAZINESS"



In many cases — bowel laziness may be due to irregular or faulty habits. Psychological factors such as fear and tension whereby the sphinctorani assumes a constant state of contraction with resultant immobility of peristaltic action often results in chronic constipation. Relaxation of the anal sphincter with YOUNG'S RECTAL DILATORS often produces good results.

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Young's Rectal Dilators are not advertised to the laity. They are available for your patients at leading pharmacies or you may order from your surgical supply house. Set of four as shown — $3.75.

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MATERNAL HEALTH

COMMITTEE ON MATERNAL MORTALITY

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Case History

Age 40. Para. 11. Ten previous vertex presentations with spontaneous deliveries. Last menstruation December 5, 1939. Seen by her family physician four or five times during her pregnancy, the last time three or four weeks previous to her admission to a hospital. At this visit the urine showed a heavy trace of albumen and the blood pressure was 170/120. Admitted at 8:10 A. M., September 7, 1940. Labor began at 6:15 P. M., the previous day. Sent to the Hospital because labor was longer than previous labors and her attending physician thought there was a mal-position of the foetus. In the morning of the day of admission the blood pressure was said to have been 170/110. On admission temperature 97.6, pulse 84, respirations 20, blood pressure 140/90. Urine negative. Bloody show. Presenting part could not be reached by rectal examination. Cervix two fingers dilated. Membranes intact. Two minute pains. Membranes ruptured spontaneously at 9:45 A. M. As little progress was apparent a vaginal examination was made at 11 A. M. Vertex presenting, high, in left transverse position, cervix soft, 3½ fingers dilated. After examination foetal heart was 144 in left lower quadrant. Within a few minutes after this examination the patient went into shock and the foetal heart could not be heard. The patient being already on the delivery table she was hurriedly prepared for delivery. Condition poor. Pulse 124. Systolic blood pressure 70. There was no material change in condition found by vaginal examination a half hour previously. As the head was still not engaged and in transverse position, version and extraction seemed preferable to high forceps operation. When the head was displaced there was a gush of bloody fluid from the uterus. Before the foot could be brought down the placenta was expelled. A rapid, easy version and extraction was done and a stillborn seven pounds, five ounces foetus delivered at 11:57 A. M. There was no abnormal vaginal bleeding postpartum. In spite of the administration of coramine, 5% glucose in saline, oxygen and 600 c. c. of blood by vein the patient failed to rally and died at 11:50 P. M.

Autopsy:—The peritoneal cavity was filled with blood. There was a tear at about the level of the lower uterine segment encircling the uterus except for a posterior portion about 3 c.m. across. The placental site was rather high on the posterior wall. The operator believes that the rupture occurred when the patient went into shock and the reason it was not discovered during the version was that the hand was inserted posterior to the head. Therefore it was assumed that the shock was due to premature separation of the placenta and hemorrhage.

Before delivery both spontaneous rupture of the uterus and premature separation of the placenta were considered but the finding at operation seemed to clinch the diagnosis of separation of the placenta as the cause of the initial shock and the treatment was therefore directed to combating the shock and hemorrhage.

Cause of Death:—Premature separation of the placenta; hemorrhage, rupture of the uterus. OBSTETRICAL DEATH.

Discussion

The immediate cause of death in this case was hemorrhage from a prematurely separated placenta and rupture of the uterus. When the rupture of the uterus occurred it is impossible to say. The history states that "a rapid easy version and extraction was done." The cervix was not fully dilated (3½ fingers). It is possible that the rupture occurred during the version and extraction. Spontaneous rupture of the uterus without obstruction due either to a contracted pelvis or tumors in the pelvis usually occurs in women who have had many pregnancies. This patient had had ten previous spontaneous deliveries so that it is possible, also, that the rupture was not due to the rapid version and extraction but was spontaneous and due to a weakening of the uterine wall. There can be no criticism of the management of this case after labor began. The family doctor rightly sensed that he was dealing with an abnormal case. The hospital staff quite properly waited for further dilatation of the cervix before attempting delivery. Neither the premature separation of the placenta or rupture of the uterus could have been foreseen.

continued on page 498

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DISTRICT SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

Meeting called to order at 9:30 P. M. on Tuesday, June 27, 1944, with Dr. Dotterer presiding, the meeting being a joint meeting being held with the Newport County Dental Society.

The guest speaker of the evening was Dr. Richard W. Lawrence, U.S.N.D.C.R., who presented a paper on diagnosis and treatment of fractures of the jaw as follows: Diagnosis of a fracture of the jaw presents certain symptoms which are pathognomonic of the conditions such as, pain, swelling, and displacement or lack of occlusion. The pain may be mild or severe and there may or may not be much displacement. The X-ray is an essential factor in diagnosis in as much as it confirms the diagnosis, locates the fracture and determines the presence or absence of teeth in the line of fracture.

Order of frequencies of fractures are as follows:

1. Single fracture of the mandible through middle foreman.

2. Angle of the jaw which may be due to presence of third molar.

3. Multiple fractures.

4. Condyle fractures, which may be uni-lateral or bi-lateral.

5. Maxillary which may be uni-lateral or bilateral.

If teeth are found in the line of fracture it is best to remove the tooth, otherwise it will act as a foreign body and portal of entry for infection; it is more important to treat shock before attempting to set the fracture. A Barton bandage is well utilized in holding the jaw until the time for setting the fracture.

Treatment of Mandibular fracture:

It is important to use the simplest type of appliance in setting fractures, preferably Winters. If fracture of mandible is present novocaine may be used to block off nerves.

Types of Appliances:

1. Cast Type.

2. Staeder Type, this is a poor method in as much as pins may loosen and move resulting in excessive scarring of facial tissues with resulting deformity.

3. Dentures as splints: in endentulous cases using bandages for holding up mandible.

Moxillary Fractures:

1. Wiring
   (a) Kingsley splint with plaster cast of skull.
   (b) Strap appliances.

Complications:

1. Osteomyelitis, which may be due to trauma or infection, treatment being penicillin, currettage, and metaphen.

2. Non-unions or faulty union fracture curretted.

3. Deformity which may be due to disease or faulty fixation of parts.

Treatment:

1. Never place wires on gums.

2. Irrigate with solutions.

3. Liquid diet.

4. For the first five days keep patient in bed, then allow up and remove appliances five weeks later.

Dr. Lawrence then showed X-rays of several cases illustrating the treatment with after results.

Dr. Mathers then presided over the dental contingent and a discussion of the paper followed by Drs. J. Rice and William Ladd Moody. Dr. Dring, President of the State Dental Society, thanked the Medical Society for the joint meeting and praised the work that was done by Dr. Sullivan, former President of the State Medical Society, for his co-operation in allowing the State Dental Society to use the RHODE ISLAND MEDICAL JOURNAL as a medium for their editorials.

Following this a business meeting was held in which no old business was taken up. Under new business the application of Dr. Martin O. Grimes was received and accepted. Meeting adjourned at 10:45, collation followed.

PHILOMEN P. CIARLA, M.D., *Secretary*

WASHINGTON COUNTY MEDICAL SOCIETY

A meeting of the Washington County Medical Society was held at the Dunes Club, Narragansett Pier, on Wednesday, July 12. One of the largest attendances of the year was registered for the meeting.

continued on page 483



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DISTRICT SOCIETY MEETINGS

continued from page 481

The Society was addressed by Dr. Alex M. Burgess, of Providence, delegate of the State Medical Society to the meetings of the American Medical Association. Dr. Burgess reviewed the work of the House of Delegates of the AMA, and then gave an interesting report on some of the outstanding scientific exhibits and the findings advanced as the result of some recent research in medical matters.

Dr. B. Earl Clarke, vice president of the Providence Medical Association, spoke of plans for the development of postgraduate medical studies in the State, and the speaking program was concluded with a brief report on the activities of the State Medical Society by John E. Farrell, executive secretary.

A luncheon at the Club was followed by an afternoon of golf and bathing.

JULIANA R. TATUM, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The officers of the Kent County Medical Society for the current year, as reported by the Secretary, are as follows:

President, Edward A. Kostyla, M.D.
Vice President, Leo H. Duquette, M.D.
Secretary, Benjamin F. Tefft, M.D.
Treasurer, John A. Mack, M.D.
Delegate, Rocco Abbate, M.D.
Councillor, Rocco Abbate, M.D.

Censors

(1942-44) Stanley D. Davies, M.D.
(1943-45) Fenwick G. Taggart, M.D.
(1944-46) George B. Farrell, M.D.

Ethics

(1945) Fenwick G. Taggart, M.D.
(1946) John A. Mack, M.D.
(1947) Jeanette E. V. Vidal, M.D.
(1944) Benjamin F. Tefft, M.D.

Trustees

(1946) Fernand J. Hemond, M.D.
(1945) George B. Farrell, M.D.
(1944) Raymond Luft, M.D.

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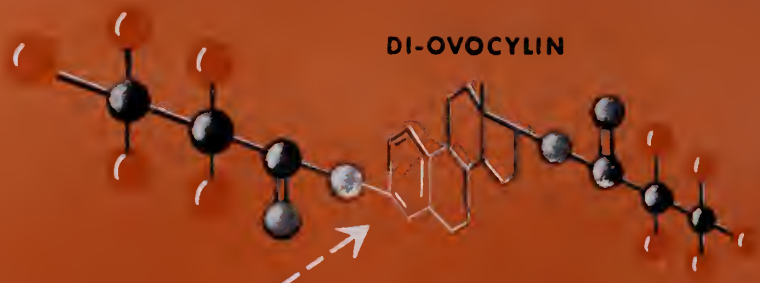
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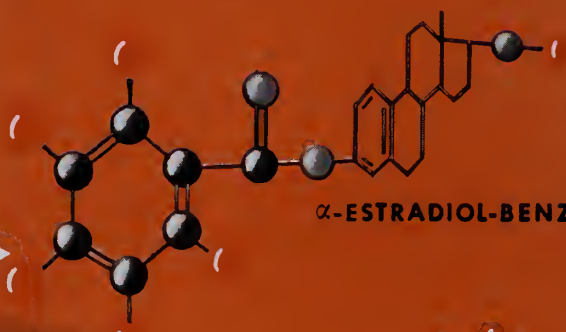


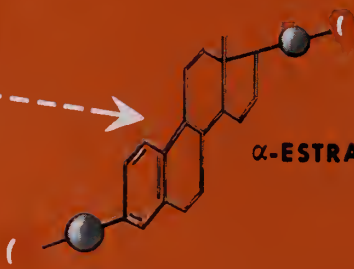
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ANNUAL REPORTS . . . 1944

COMMITTEE ON TUBERCULOSIS

Your Committee has had four meetings this winter and spring, all in conjunction with the Committee on Tuberculosis of the Providence Medical Society. There have been three chief topics of consideration. One, promotion of use of the mobile x-ray unit of the Providence Tuberculosis League, two, the follow-up of cases of tuberculosis of residents of Providence discovered at the Induction Center, three, follow-up of similar cases elsewhere in the State.

We have also reviewed the status of pneumothorax clinics throughout the State. Such clinics have been functioning in Newport, Warren, Cranston, Westerly, and Providence and have been serving a very useful purpose. There have yet been no clinics established in Pawtucket or Woonsocket, but there is still hope that there will be in the not too distant future.

In regard to the mobile unit unfortunately it has not been used to anywhere near its full capacity. Apparently the chief reason for this has been the lack of time on the part of plant physicians. A good deal of reliance has been placed on them to make arrangements with plant managers and employees. While they have in general shown willingness to cooperate the results could not be all that was desired. On discussing these problems it was decided that it would be satisfactory for Dr. Pinckney, with the consent of the individual plant physician, to work directly with the plant management in making these arrangements.

The question as to whether there would be any conflict of interest if the mobile unit were permitted to be used in plants or for other groups outside the city of Providence has been discussed and after putting the matter before various groups who have interest in this field there seems little doubt but what such use of the unit would be desirable from the standpoint of all concerned. To further stimulate the use of this apparatus, which we feel is a very valuable adjunct in tuberculosis case finding, we have discussed at considerable length other approaches to the problem. The result has been that the Committee deems it advisable to have a meeting of representatives from various groups who are directly concerned with the problem. These groups include your Committee, leading labor organizations, R. I. Society of Industrial Physicians and Surgeons, departments of Health of both the City and the State, the Chamber of Commerce, organizations of industrial management, and Post-War Planning Board.

The question was posed as to whether it would be advisable to set the mobile unit up in a given manufacturing center and encourage individuals in the vicinity to make use of it. It was felt by the Committee, however, that this method would not be a satisfactory way of approaching the problem.

In regard to the follow-up of cases discovered at the Induction Center an attempt was made to determine to what extent they were followed after having been turned down by the Armed Forces. The Director of Tuberculosis of the City of Providence found that up to the Fall of 1943 two hundred and seventy-two men had been rejected on the basis of x-ray findings of tuberculosis lesion. Of these two hundred and twenty-nine had been seen either by the Charles V. Chapin Hospital, private physicians, or by District Nursing Associations. Forty-three had not been reached because either they were not known at the address given or they made no response to letters. In discussing this with Dr. Deery who has been doing the x-ray work at the Induction Center he stated that he would in the future refer all suspicious cases to their local physicians or to a proper clinic according to circumstances of the case. Also he stated that facilities would be arranged for more accurate listing of the addresses of examinees.

It was felt that physicians sometimes do not fully appreciate the opportunities for improving the control of tuberculosis that is given by these Selective Service examinations. Therefore, it was decided that an editorial in the Rhode Island Medical Journal would be advisable encouraging physicians to make use of all available facilities for determining the exact significance of lesions reported by Selective Service and urging the carrying out of proper measures. This editorial has not yet been placed but it is our plan to make arrangements for this with the approval of the Editorial Board.

On investigating the status of follow-ups in the State outside the City of Providence it was found that the results had been less satisfactory. This was to be expected in that the office of Director of Tuberculosis for the State has been but recently set up, and is in a relatively early stage of organization. The Director is considerably handicapped by lack of proper facilities for carrying out his work. The follow-up of these cases in general has run from 25 to 75 per cent as far as can be determined, with the exception of clinics in Apponaug and Warren where the results are reported to have been close to 100 per cent. In this situation there has not been a very uniform method for carrying out the work. However, arrangements have been made to have the cases found at the Induction Center reported to the proper state authority so that a check can be more readily made.

Little has been done thus far in regard to follow-up of people discharged from the Armed Forces because of tuberculous or suspected tubercular lesions. The plans for this are at present under discussion but nothing definite has yet been formulated.

Your Committee is anxious to serve whatever useful purpose it may and invites any recommendations that you may have. There have been no very definite directions given to the Committee as to what their duties and responsibilities are.

John C. Ham, M.D., *Chairman*

Philip Batchelder, M.D., Katherine Barr, M.D., James P. Deery, M.D., Peter F. Harrington, M.D., Royal Hudson, M.D., George A. Keegan, M.D., John I. Pinckney, M.D., Florence M. Ross, M.D., D. A. Smith, M.D., C. L. Southey, M.D., U. E. Zambarano, M.D.

continued on page 487

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ANNUAL REPORTS

continued from page 485

COMMITTEE ON WAR PARTICIPATION

This Committee, recommended by the American Medical Association and appointed last Fall by your President, functions principally for the purpose of keeping records of and personal touch with the members of the Society, both in active and inactive Military Service, as well as with those in civilian life whose activities have to do with the war effort.

The Society has so completely and whole-heartedly cooperated with all outside agencies concerned in this effort, that the War Participation Committee does not feel called upon to enter the general field of contact with such agencies.

Our Society through its Officers and Executive Secretary has been prompt in responding to all requests for assistance and has taken the leadership amongst the State Societies in helping to solve many problems in the furtherance of war activities, such as:

1. Complete observance of O.P.A. regulations.
2. Preparation of Medical Certificate of Availability for use by War Manpower Commission.
3. Development of the Keep Well Crusade and Civilian War Service of the State Council of Defense.
4. Formation of a Medical Advisory Committee to the O.P.A.

All these matters are covered elsewhere—ours is the personnel and personal problem.

Figures and Statistics: Number of Society Members in Service, 175; Invalided, out 7; Deaths, 2.

ARMY: Lieutenants, 32; Captains, 65; Majors, 26; Lt. Colonels, 7; Colonels, 1.

NAVY: Lieutenants (jg), 5; Lieutenants (S), 17; Lt. Commanders, 17; Commanders, 5; total 175.

NUMBER PROMOTED, 39.

Society Members on Appeal Board, 6; Society Members on Local Boards, 114; Society Members on Advisory Boards, 84; Society Members on Procurement and Assignment Boards, 8.

It is reported that the increased work load resulting from the large number of younger men in the military service, this load falling largely upon the older doctors, has resulted in a higher mortality and morbidity among the latter of society members.

May 1, 1942-May 1, 1943—8 men died 60-80 years.

May 1, 1943-May 1, 1944—7 men died 60-80 years.

While these figures are of little significance, they may be of interest in comparison with those of the years which are to follow.

Whereas, through the country over 500 localities have been reported as critically short of medical personnel, no such areas have appeared in Rhode Island and none of the Society's members have been called upon to relocate for such reason.

You are so well and constantly informed through our monthly journal of the doings of our society members in active service, that this Committee need not touch upon those matters.

We would call attention to a statement in the recent report of the War Participation Committee to the House of Delegates of the American Medical Association—"It is undoubtedly true of some states that the public may have completely lost sight of the priceless voluntary feature of the military medical service rendered by 50,000 American physicians. It has been said that even line officers in military service are definitely under the impression that there is a special kind of draft for medical officers".

Your Committee suggests that all members of the Rhode Island Medical Society use every method possible to inform the public correctly that ours is a voluntary and not a drafted effort in this war.

Your Committee looks forward in the future to helpful activity on behalf of those members of the Society who are now in active service, when they return to civil life.

HALSEY DEWOLF, M.D., *Chairman*
ELIHU S. WING, M.D., LUCIUS C. KINGMAN, M.D., MICHAEL H. SULLIVAN, M.D., WILLIAM P. BUFFUM, M.D.

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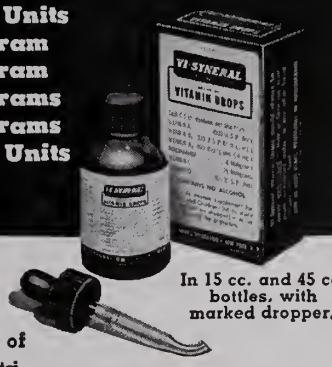
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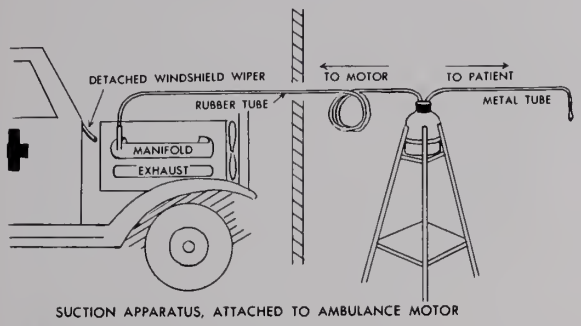
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ANESTHESIA IN THE TROPICS

continued from page 455

SKETCH 4



SUCTION APPARATUS, ATTACHED TO AMBULANCE MOTOR

Although this suction device has been satisfactory, it has been noted that the vomitus of Chinese patients usually consists of globules of congealed dry rice which are sucked out with difficulty. Attempts to wash out the stomach with a Levine tube have given similar trouble because of the small caliber of the tube.

Complications

The only mortality was mentioned above. The morbidity was relatively low. Only a very few causes of post-operative partial atelectasis resulted which subsequently cleared in 48 hours. Five cases of impending shock from administration of Percain were encountered out of a series of 225 cases and one case from Procain out of a group of 46 spinals. Of the 5 cases resulting from Percain, one went into shock immediately after the administration of the drug for an elective gall bladder, even before a proper height of anesthesia was obtained. Because of respiratory arrest the operation was postponed, and with the aid of artificial respiration the patient resumed his automatic respiratory control within ½ hour, thus further assuring that the patient did not have respiratory paralysis. His lowered blood pressure returned to normal within this time with the administration of fluids and oxygen. The patient was later operated upon under ether anesthesia without untoward effect.

Summary

An attempt has been made to present the highlights and discuss the difficulties of a series of 1028 cases given anesthesia. A few methods devised to compensate for lack of proper equipment have been presented so that other hospital groups may profit if handicapped under similar circumstances. It is generally conceded that the average Chinese patient is a constitutionally robust individual without the slightest fear for surgery. If a sufficiently small Chinese vocabulary is mastered to familiarize the patient with the anesthetic procedures to take place, a relatively easy anesthesia will usually follow.



OVER 200,000 VOLUNTEERS

continued from page 469

From this modest start, Blue Cross has now fanned out into every state.

Blue Cross is more than an idea, however; it also represents an ideal. As a group pre-payment program for hospital care, it possesses many features which are unique, but in its broader aspects, as an ideal made practical by an idea, its course has been typically American. It has given public service without public compulsion, and has demonstrated private leadership without private gain. In its voluntary aspects, it stands as a bulwark against increasing Federal encroachment of the hospitalization field.

The citizens of this State have been quick to grasp both the idea and the ideal as thousands of letters on file in the headquarters of the Plan indicate. Their contents, poignant in their simplicity—"We were able to buy the baby furniture with the money we would have had to use for the hospital bill"—but complete with the understanding that comes only from experience—"I have had to call on your service three or four times now, and it surely has been a blessing and a great help to my family and myself to know that we have such security when needed"—are ample evidence that one reason the Plan has been successful is that thousands of Rhode Islanders have been well pleased with the service it has rendered.

The operation of the Plan is too well known to the readers of this JOURNAL to bear repetition here. Suffice to say, a liberal simplicity has been maintained, and the timely phrase "no red tape" aptly sums up the impressions of those who have had to call upon Blue Cross services.

Each year has seen a healthy increase in Blue Cross enrollment. Each year has seen added reserves, and a sound financial position. Nearly every year there has been a decrease in the expense operating ratio to the point where now the Rhode Island plan's operation cost is among the lowest in the country. On several occasions the Board of Directors have seen fit to increase benefits without raising the rates—which is in effect a lowered premium; and in at least one instance the Board declared a "dividend" to the members where an entire month's membership fees were not assessed owing to the particularly strong financial reserves in the organization.

The subscribers, of course, are not the only beneficiaries. The hospitals themselves are non-profit community institutions in which every individual has an interest. Their only purpose is to serve. They are better able to because of Blue Cross. During the past five years the Rhode Island Blue Cross has paid approximately one million eight hundred thousand dollars for hospitalization. Hospital in-

continued on page 495

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continued from page 492

comes from this source are regular and assured, and the income from Blue Cross, which has been increasing annually, may be depended upon year in and year out.

Never before in their history have the hospitals been able to remove so much uncertainty from their method of operation. Like their Blue Cross patients they are eliminating a worry through the prepayment service. They can plan more orderly development because more orderly income is assured. What the Blue Cross really amounts to is an agreement between the hospitals and the people they serve. The people agree to budget small regular amounts in support of the hospitals. In return the hospitals agree to furnish their services in time of need.

As every physician knows, early treatment speeds recovery. The number of working days which have been saved because of early hospitalization is something that can never be estimated accurately, but it is a potent factor in these harried days of manpower shortages when every ounce of energy and productivity is needed for successful prosecution of the war on the home front. As a further, but nonetheless notable achievement of Blue Cross, many patients have been able to meet doctor's bills more promptly now that they have the benefits of prepaid hospitalization available.

Now the Blue Cross is widening its horizons to provide a further service to the citizens of this State. Starting this month, the Plan offers two new contracts to residents and employees of Rhode Island. The first, and most comprehensive, offers 45 days of hospitalization to individuals and their dependents employed in Rhode Island industry where at least 90% of the workers become subscribers. Industry will be offered the opportunity of sharing in either a portion of the cost or may, if it so desires, assume the entire membership fee for an employee and his dependents.

The second offering opens up an entirely new field. The self-employed, unemployed, and retired are to be given the opportunity of membership on a direct enrollment basis. Rhode Island Blue Cross thus becomes one of the first of the recognized Hospital Service Plans to present opportunities of membership direct to physicians and other professional men on a direct enrollment basis. Through able leadership and "the stamp of liberalism upon the charter" which the founding fathers hoped for, Blue Cross has been able to choose intelligently between the advantages of voluntary enrollment and the dangers of federal compulsion.

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SICK HEADACHES

continued from page 467

When gynergen does not work perfectly, and vomiting persists, a three-grain (0.2 gm.) rectal suppository of pentobarbital sodium (nembutal) will often bring rest and sleep and the end of the attack. Sedatives of any type can be given per rectum with the help of a small rectal bulb syringe such as is used for babies.

In all cases it helps greatly if the woman can lie down in a darkened room as soon as an attack threatens. Oftentimes, then, the taking of aspirin, or aspirin with a half grain of codein, or two cups of black coffee, or two tablets of bromural will help.

Summary

Migraine is an entity—a hereditary peculiarity of the brain and the temperament. Hence it is useless to search through the body for the "cause." Even when a diseased tooth, sinus, gallbladder, appendix, uterus, or ovary can be found and removed, the patient is likely soon to be having her headaches again, because the tendency remains unchanged.

It is very helpful diagnostically to recognize the typical migrainous personality. There are atypical migraines and migraine equivalents.

The best way in which to avoid migraine is to live quietly and peacefully and sanely. To relieve attacks the best drug is ergotamine tartrate or gynergen. It should be given intramuscularly—not orally or intravenously.

The best time in which to abort an attack is when it starts. After nausea sets in medicines are not well absorbed from the stomach. They can then be given per rectum.

MATERNAL HEALTH

continued from page 478

It is worth noting that as in this case rupture of the uterus is by no means always followed by excessive bleeding externally. The bleeding from the rupture is often into the peritoneal cavity and not into the vagina.

The antepartum care is not above criticism. "Three or four weeks" before her due date the urine showed a heavy trace of albumen and her blood pressure was 170/120. Immediate admission to a hospital and appropriate treatment might have prevented the premature separation of the placenta which is an ever present hazard in hypertensive disease in pregnancy whether due to essential hypertension, chronic nephritis or true toxaemia of pregnancy.

These conditions are still a major cause of maternal deaths. They will continue to be as long as patients and the medical profession fail to appreciate that they are extremely dangerous complications of pregnancy and demand frequent urine examinations and blood pressure readings with prompt and vigorous treatment if albuminuria, rapid increase in weight or a rise in blood pressure develop.

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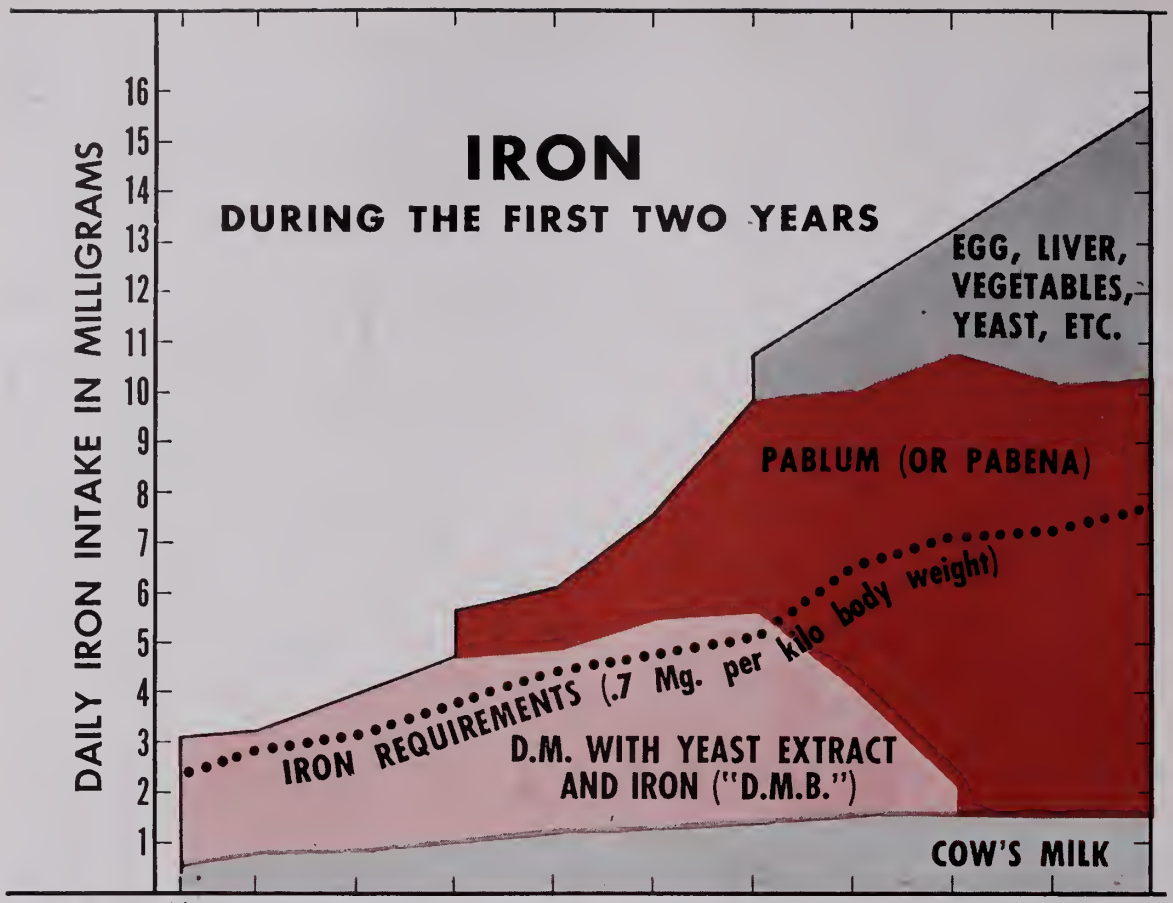
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Volume XXVII, No. 10 Contents Page 503

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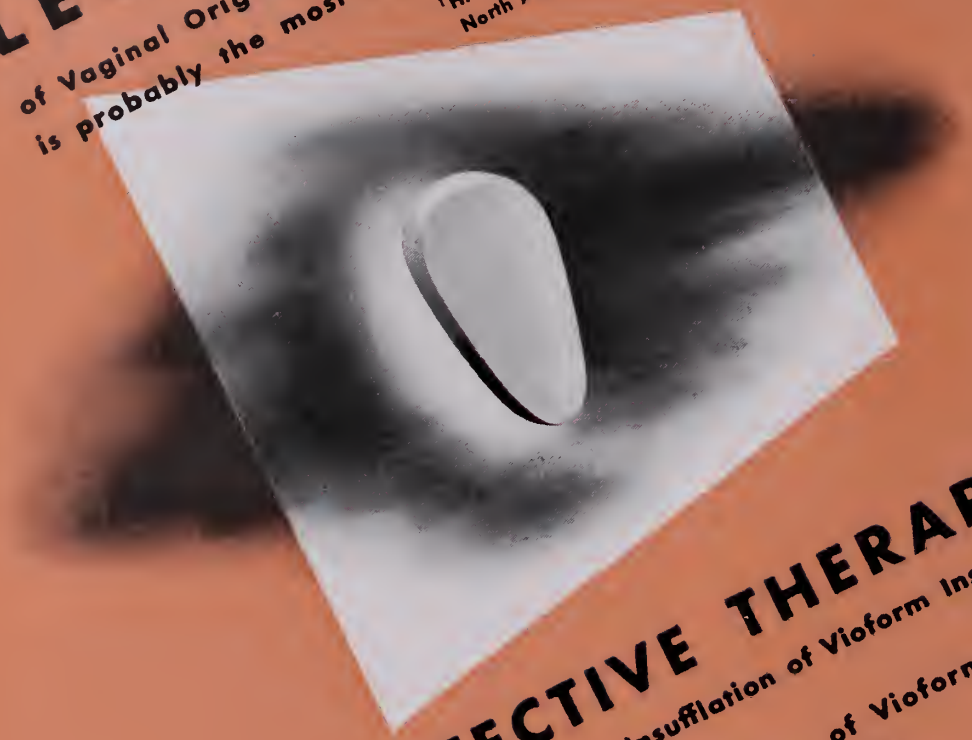
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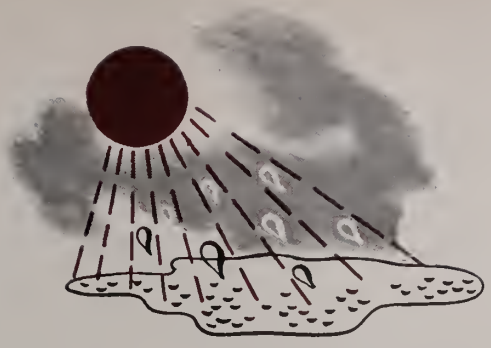
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The RHODE ISLAND MEDICAL JOURNAL

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THE DIAGNOSIS OF PEPTIC ULCER

EDWARD S. EMERY, JR., M.D.

The Author. *Edward S. Emery, Jr., M.D. of Boston. Senior Associate in Medicine, Peter Bent Brigham Hospital.*

THE diagnosis of peptic ulcer usually can be made in less time and with more certainty when the services of a well-trained roentgenologist are available. However, one encounters a number of patients in whom the x-ray is of little assistance and who require intensive clinical study before a correct diagnosis can be made. The size of this group is such that it not only cannot be ignored, but is deserving of the most careful attention and failure to make a correct diagnosis is a serious matter. Therefore, I wish to discuss the symptoms, signs and laboratory findings which are useful in distinguishing peptic ulcer from other conditions.

A knowledge of and the application of these factors may be helpful and necessary in any of the following situations:

1. The patients with ulcer in whom its presence is not revealed by the x-ray.
2. Various disorders simulating the symptoms such as:
    a. Gastritis
    b. Gallbladder disease
    c. Diaphragmatic hernia
    d. Intestinal disorders usually of a functional nature
    e. Intestinal parasites
3. Cases of gastric ulcer which have to be differentiated from carcinoma of the stomach.
4. Carcinoma of the duodenum most commonly arising in the pancreas which roentgenographically simulates a duodenal ulcer.

A thorough knowledge of peptic ulcer provides a key to the study of all gastrointestinal disorders because the disease follows a basic pattern. Familiarity with its behavior and the factors governing that behavior not only enables the physician to treat his ulcer patients correctly, but also to investigate most disturbances of the stomach and intestines.

Frequency: It is the most frequent organic affection of the gastro-intestinal tract. Stewart and Hurst[1] report that 10 percent of the population shows scars of an ulcer at postmortem examination. From a recent study[2] at the Peter Bent Brigham Hospital it appears that approximately 10 percent of all those seeking help for gastrointestinal complaints and 2 percent of all patients consulting physicians for any cause, suffer from this disease.

Age: It is essentially a disease of young adult life although symptoms may first develop at any age. Careful histories reveal that these patients who consult a physician for the first time in later life, may have had the disease for many years, but the symptoms were not severe enough to require the services of a physician. It is not safe to eliminate the possibility of ulcer by age alone.

Sex: It occurs with sufficient frequency in women as well as men to make sex of no diagnostic value.

General Behavior: It is a chronic disease with periods of spontaneous remission and exacerbation, both of which may vary in duration from a few days to several years. Three to four months is the more usual length of time for these alternating cycles to exist. The failure to elicit a definite remission of symptoms must be explained before one can accept the diagnosis of ulcer as the sole cause for the symptoms.

Etiologic Factors: The basic cause of the disease is not known although several factors influence its behavior. These are 1) Nervous or emotional tension, which is the most frequent activating influence. 2) Acute or chronic infection. 3) Fatigue or exhaustion from any cause. 4) Gastric acidity. The importance of the gastric acidity as an etiological agent remains a controversial issue. This is not the place to discuss the present opinions on the subject, but only to state that I am unaware of any recent information which causes me to abandon the clinical evidence that the gastric acidity bears some relation to the symptoms and clinical behavior of these cases.

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Contrary to popular belief, diet has little or nothing to do with the reactivation of a quiescent ulcer.

Symptoms: A familiarity with the symptoms of ulcer is essential for an intelligent evaluation of patients who may be suffering from this disease. Fundamentally, the symptoms follow a definite pattern. This is an epigastric distress developing after an interval following meals and relieved by the ingestion of food and alkalies and emptying the stomach of secretion. The distress is often a gnawing or hungry sensation, but all types of sensations are described. The quality is not as important diagnostically as its behavior. The onset is always a definite time after eating although the interval varies with different individuals from 30 minutes to 3-4 hours. The occurrence of digestive symptoms before 30 minutes indicates some cause other than an uncomplicated ulcer, is responsible for the symptoms. It is uncommon for an ulcer to develop symptoms more than three hours after eating, except at night. The presence of distress around midnight to 4 a.m. is always significant, partly because ulcer is the commonest cause of pain at this time and because it usually indicates a hypersecretion if an ulcer is present.

Although the cause of the distress has never been proven, the fact that those measures which are used for temporary relief decrease free acidity, lends strong support to the idea that free acidity is associated with the distress. Furthermore, the typical distress of ulcer occurs only when free acid is present in the stomach. Whatever one's view may be on the relationship of free acid to pain, one is not clinically justified in accepting a distress as due to ulcer which does not fulfill these criteria. Pain is frequently referred to the back when the ulcer is penetrating the posterior abdominal wall.

Unfortunately, there are many factors which will influence or blur the clearness of the typical pattern of the ulcer symptoms. Penetration of the gastric or duodenal walls, sufficient to produce a local peritonitis causes discomfort almost immediately after the ingestion of food. The development of obstruction will modify the symptoms. Symptoms from associated conditions such as emotional tension, a complicating gastritis, gallbladder disease may be sufficiently frequent or severe to overshadow the familiar ulcer pattern which may then be impossible to elicit until the patient has been educated to observe and recognize the qualities of an ulcer distress. Interference with the typical symptoms occurs so often that many clinicians conclude that there is no characteristic pattern with the result that they do not attempt to look for it. This is unfortunate because there are many patients on whom a diagnosis can be made and suitable therapy provided only by a correct evaluation of the symptoms.

Laboratory Data: A gastric analysis provides information on whether the stomach secretes acid, the volume of secretion and whether a 12-hour retention is present. The knowledge that a stomach is unable to secrete hydrochloric acid rules out a peptic ulcer as the cause of a patient's distress. Titration of the free acid has a limited value. A low figure is usually found in patients with rather mild symptoms and an incompatibility in this regard should cause one to look for another explanation of severe pain. If there is a question of cancer, a low acidity may make one lean toward a malignant process, but a high figure for free acid does not rule it out. Figures on the titratable acidity give little indication of the probable response to therapy, unless the figure reaches 80 or more.[3] However, the volume of secretion as determined by the Bloomfield method is a valuable index to the probable response of the disease to treatment. A secretion over the normal values of 1.5 cubic centimeters per minute indicates that the disease will respond poorly and intensive treatment must be instituted. Marginal ulcers are prone to develop in the presence of a hypersecretion and radical gastric resections are indicated if surgery is to be attempted.

The presence of yeast cells and sarcinae reveal a 12-hour gastric retention and may contribute useful information about the presence or degree of pyloric obstruction.

The acid test of Palmer was devised on the belief that free acid is associated with the presence of ulcer distress Although the test is not specific for a peptic ulcer it helps to differentiate ulcerous lesions in the stomach and duodenum from trouble arising in other places. It is a test which could be used more often in doubtful situations. Although unable to supplant the x-ray, gastroscopy provides useful information in a number of ways. Perhaps its most valuable function is to determine the presence or absence of a gastritis to explain a suggestive ulcer distress, or a gastrointestinal bleeding when the x-ray fails to reveal an ulcer. At times it is desirable to know the type and severity of a gastritis existing along with an ulcer. Occasionally, gastroscopy will visualize an ulcer which the x-ray cannot demonstrate. The procedure is also an aid in distinguishing between a benign and malignant ulcer of the stomach.

The Patient With Ulcer Symptoms in Whom an Ulcer Deformity Is Not Demonstrated

Cases of this type may be suffering from:—

a. An ulcer which is not demonstrated by the x-ray

b. Other conditions producing ulcer-like symptoms.

Physicians are naturally loathe to diagnose an ulcer in the absence of roentgenological support. However, Schnitker and Evans[5] found from a study at the Peter Bent Brigham Hospital, that 3.3 percent of the cases that were finally proved to be ulcer failed to show a deformity at the first examination. This figure might have been larger if all the patients who were suspected of having an ulcer could have been followed. However, the incidence of 3 percent is large enough to justify a tentative diagnosis *provided the symptoms are characteristic and provided other causes for the symptoms have been eliminated.*

Ulcer versus Gastritis

Gastritis is the commonest of other causes for producing ulcerlike symptoms. Wayne Gorden[6] has found that all types of gastritis may produce these symptoms in the presence of free hydrochloric acid although the hypertrophic type is most frequently encountered in this connection.

The differential diagnosis between peptic ulcer and gastritis depends upon the symptoms and gastroscopy. *X-ray studies* ordinarily do not help much in distinguishing between the thickened rugae frequently encountered with peptic ulcer and the superficial and hypertrophic types of gastritis.

Symptoms: In general, the symptoms of the so-called gastridities are somewhat more variable than those of ulcer, particularly in their time relationship to meals. Whereas, the symptoms of ulcer maintain the same interval after eating in any one patient, the symptoms of gastritis may vary by as much as an hour or more. Superficial gastritis may produce symptoms immediately upon eating or within 30 minutes after eating which is against ulcer. Hypertrophic gastritis may not respond as completely to treatment as ulcer and after intensive therapy has been stopped may not remain free of symptoms for as long as ulcer.

Gastroscopy: Direct visualization of the stomach wall provides the best means of determining whether or not a true gastritis exists and the type of gastritis present.

A failure to find definite evidence for gastritis favors peptic ulcer in the type of cases under consideration, although the presence of gastritis does not rule it out. According to Bockus[7], Schindler and Baxmeier were unable to find any gastritis in 43 of 91 patients with gastric ulcer. Some evidence for gastritis was found in thirty-nine. Christiansen has found no correlation between the type of gastritis and duodenal ulcer. Of 70 patients studied, chronic superficial gastritis was present in 34, chronic hypertrophic gastritis in 8 and atrophic gastritis in one.

These findings do not harmonize with the large incidence of thickened rugae observed by the x-ray in the presence of ulcer. Further studies on the possible relationship of gastritis to ulcer are indicated. At present, we must rest content with the knowledge that various kinds of gastritis may be found in the same patient with ulcer and that the gastridities may simulate ulcer symptoms.

Therefore, the differential diagnosis between ulcer and gastritis is made on the evaluation of the symptoms and gastroscopic findings.

There are other disorders such as a diseased gallbladder, diaphragmatic hiatus, even intestinal parasites, which may cause symptoms suggestive of ulcer. It would make this paper too long if I attempted to discuss them all in detail. In these situations a correct diagnosis can be made if the symptoms are evaluated on the typical pattern of the ulcer distress together with careful laboratory studies. I want to turn now to another important aspect in the differential diagnosis of ulcer, namely:

The differentiation of a malignant from a benign ulcer of the stomach

One may ask, why bother to distinguish between them. Why not operate on all gastric lesions as surgery is an accepted form of treatment for a peptic ulcer as well as cancer. The answer is that such a program would cause many patients to undergo unnecessary operations as the number of malignant lesions which simulate an ulcer is not great. About 95 percent of the lesions occurring on the lesser curvature are benign and most of these respond satisfactorily to medical treatment. Furthermore, a peptic ulcer rarely if ever becomes malignant.

Finally, careful study will distinguish the two types of ulceration in most instances. However, it is necessary to watch all gastric lesions carefully and if there is any doubt about the ultimate diagnosis, surgery should be recommended.

Symptoms: A failure to elicit typical ulcer symptoms should make one suspect a malignant lesion. However, the presence of ulcer symptoms does not eliminate the possibility of cancer which can closely simulate a benign lesion.

Gastric Acidity: It is desirable to know the gastric acidity. A lesion found in a stomach which is unable to secrete any hydrochloric acid must be considered malignant. A low free acidity of not over 25 points favors malignancy, but does not rule out a benign lesion. A high acid does not eliminate a cancer. Similarly, an ulcer response to Palmer's acid test does not eliminate cancer although a failure to respond to the test strongly favors a carcinoma.

Location: The location of the lesion is important. The majority of lesions within the first inch proximal to the pylorus are malignant. Most clin-

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MEDICAL EDUCATION — OLD PURPOSES AND NEW METHODS*

HENRY R. VIETS, M.D.

The Author. *Henry R. Viets, M.D., of Boston. Librarian of the Boston Medical Library.*

FOR the privilege of addressing this convocation, inaugurating another link in the cordial bond that has always existed between Brown University and the medical profession, the reader is deeply indebted to the University officers and his medical colleagues in Providence. Long interested in the history of my calling and in the education of the doctor, I find an opportunity in this occasion to set down a few thoughts that seem pertinent to the subject, largely based on the experiences of my own education, without attempting, if indeed I were capable, to quiet the turbulent waters whirlpooling around the problem of medical education in general. If I only succeed in breaking the shore-ice, perhaps we will have a clearer view of the goal, the doctor fully equipped and ready to serve his fellow man. The objective of medical education is the same today as always: only the methods of reaching the academic end of the journey, rightfully called "commencement", have changed with the passing years. Brown University once travelled this road; some of the wayfarers set down an account of what be-fell them and we may profitably stop to review briefly their enlightened experience.

In the early Nineteenth Century, Brown University, as was the custom of the time, bestowed upon its medical worthies, most of whom had seen the inside of her academic halls, but had of course never attended a medical school, an honorary degree of Doctor of Medicine. Harvard University followed the same practice. For an earned degree in medicine at the Harvard Medical School, the procedure was to grant a degree of Bachelor of Medicine at the time of graduation and follow this, seven years later and after another examination, with the degree of M.D. In the intervening years the doctor assisted one of the older men or, if bold enough, struck out for himself. In 1811, however, came a decided change in Harvard University policy for in that year the granting of the degree of M.B. was abolished and all medical graduates from then on received the degree of M.D. To the holder of the M.B., graduated in the previous seven years, also went the M.D., an interesting reshuffle bringing all the medical graduates up to an even level. If Brown University was to give a degree of M.D. on graduation, Harvard University could not lag behind; or was it Harvard who stimulated Brown to start their medical school the same year?

*Read at the Medical Convocation, Brown University, Providence, R. I., August 9, 1944.

The Influence of Benjamin Waterhouse

The answer is not clear, but a sound reason for the beginning of the Brown University Medical School lies in the growing realization on the part of the younger men in medicine throughout the colonies, many of them by this time trained abroad, that adequate clinical facilities were an essential part of a complete course of medical instruction. The Harvard Medical School, situated in Cambridge in 1811, was greatly influenced by Benjamin Waterhouse, who only had to walk a few steps across the green from his house to the lecture hall. He bitterly opposed moving the school to Boston, to be near the then contemplated Massachusetts General Hospital, a suggestion that had come from two young firebrands in medicine, John Collins Warren and James Jackson. Waterhouse, after endeavoring to establish a rival school which had an ephemeral existence, finally was forced to resign from the Harvard Medical School faculty in 1812. The attack of these spirited young men against the limitation of medical instruction to didactic lectures, quite possibly stirred the imagination of Solomon Drowne in Providence, a wise practicing physician, long a member of the Board of Fellows of Brown University. It was he, you will recall, who suggested to President Messer the idea of a medical school at Brown and promoted its establishment in 1811, the very year that the Harvard Medical School was shaking with faculty dissension. The two physicians who joined Drowne in beginning the school at Brown, William Ingalls and William Corlis Bowen, were also practitioners of medicine, thus reinforcing our surmise that the ferment in Boston and Cambridge, based on the desire to study disease at the bedside was also at work in Providence.

Although Professor Drowne's prescriptions seem to have been mainly composed of "butter-nut pills, decoction of mallows and pussy-willow tea",

he did care for the sick in addition to giving his botanical lectures and without doubt realized the importance of teaching his students the art of practice, as well as instructing them in the intricacies of raising herbs on the slopes of Mount Hygeia. Ingalls, moreover, was a surgeon actively engaged in his profession, as well as a teacher of anatomy, and Bowen, the chemist, continued in practice, as had his long line of outstanding medical ancestors, who, as Goddard quaintly remarks, "Signalized in the medical history of Rhode Island, by no ordinary attainments in professional science, and by a diligently, successful and honorable practice."[1] Bowen died, tragically, of chlorine poisoning in his thirtieth year, while experimenting with this drug as a bleaching agent, just prior to the establishment of that industry in Providence. Coming in 1815, only four years after the infant school of medicine was established, this must have been a hard blow, for Bowen gave every promise of a brilliant career. The School, however, survived with vigor, stimulated greatly a few years later by Commodore Perry's surgeon's mate, Usher Parsons.

Of the ninety odd graduates of the Brown University Medical School, a few attained places of high distinction in the profession: Jerome V. C. Smith as a medical editor; Alden March in medical education and Elisha Bartlett, that peripatetic professor and Osler's "Rhode Island Philosopher", who enlightened the students in no less than nine medical schools of his day.

Brown Medical School Closed in 1826

When Dr. Messer resigned as President of Brown University in 1826, the Reverend Francis Wayland, Jr., of Boston, became President. He was a man of pronounced convictions and, unfortunately for medical education, one of his most unwavering beliefs was that all professors in the University should live in residence, devoting their entire time to work in their respective departments, as part of an academic family. President Wayland does not seem to have visualized the advantages of "combining academic drill with the invigorating breezes from the outside world of public and professional life."[2] A situation impossible of profitable solution was at once provoked in the Medical School and its doors were closed the same year. As Charles W. Parsons puts it: "In drawing the reins up so suddenly and turning so sharp a corner, it was not strange that something should be jolted out, and the Medical School had the loosest hold."[3] The names of the professors continued in the catalogue for a few years but apparently instruction was not given and the School became a thing of the past, much to the regret no doubt of the local physicians, and indeed to the former teachers who had served it so efficiently. The School in its fifteen years of existence had established a sound reputation and we can look back now with pride at an outstanding effort in medical education by Brown University in an age when the doctor-student apprentice system was slowly evolving into a more formal type of teaching doctors the art and science of their vocation.

Although those "invigorating breezes from the outside world" were largely shut out in 1826, as far as medicine was concerned, by President Wayland's action, the University did not entirely give up its neighborly relations with the doctors and the community they served. Providence was too closely knit for that. After the establishment of the Rhode Island Medical Society in 1812, Brown honored that Society by giving the honorary degree of M.D. to many of its Presidents, but this pleasant custom seems to have been abandoned by 1828. Of more importance to us today was the Brown University Medical Association, consisting of professors, students and resident physicians, founded in 1811 and surviving until 1825. Weekly meetings were held and a library was formed for the use of all. In this association was the germ of an idea, now, in 1944, worthy of being re-cultivated and made productive.

University Relations With Medicine

In part, at least, Brown University never quite cloistered itself from the whole community. In the nineteenth century, lectures on natural philosophy and chemistry were often arranged for the public and the idea of "university extension" was given a practical outlet from time to time. For medicine, however, the stream seems to have run nearly dry, although a Brown University Medical Association may have continued to exist throughout the century after the Medical School was closed. At least there was a Medical Association alive in 1896, for it was duly recognized on that date by Dr. W. W. Keen, one of Brown's most distinguished graduates. Keen's paper, on the requirement for a professional career in medicine,[4] written for the 'Brown University Magazine', touched, among other things, upon the value of studies in the humanities under inspiring teachers. A student, he wrote, "will be none the worse a doctor if he can read an ode of Horace, or a page of Homer, nor will he handle the scalpel any less deftly if he knows Shakespeare by heart or owns a well-thumbed Goethe." Coming from one of the most active surgeons of his day, always in the forefront of his profession both in the technique of surgery and in the advancement of knowledge by experimentation, later called 'research', Keen's words echo my thoughts today. I do not mean, of course, that one must be versed exclusively in the humanities to qualify as a great, or even, a sound doctor. Good moral character, good manners, perseverence and studiousness are, as always, the four characteristics necessary to make

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a successful physician. The master word, as Osler pointed out, is "work" and doctors, who rarely appear in the bankruptcy courts, know the truth of Emerson's comforting statement: "Make yourself necessary to the world, and mankind will give you bread". Sir James Paget, in a famous paper on, "What Becomes of Medical Students", found that sixty per cent achieved success, in varying degrees, eighteen per cent had "very limited success" and twenty-two per cent died or left the profession. Keen, who falls high in Paget's scale, felt that the place a doctor takes among his fellows, both of his own calling and in the entire community, depended not a little, "on his ability to set forth his ideas clearly, logically, forcibly." In this, Keen's training in the humanities at Brown University was, as he states, invaluable to him in later life. Others, besides Keen, who have risen to heights, have expressed their indebtedness to their undergraduate instruction and I believe the inspiration behind this convocation, bringing together the academic faculty of a great University, and the "outside breeze" of men actively engaged in the practice of medicine is essentially based on a desire to develop a modernized "angelical conjunction", between *magister* and *medicus*.

Duties of University to Profession

The duties of the University to the profession lie in many fields: the undergraduate, aspiring to become a student of medicine; the recent graduate, earning his laurels in hospital or clinic; the practitioner, striving to cope with the rushing tide of rapidly advancing medicine in chemotherapy, biotherapy or surgery; the weary doctor home from the beaches of Salerno and Normandy or from the fever-infested lands of the South Pacific and the advanced student, who wishes to search out the estrogenic or gonadotrophic hormones or explore the possible germicidal properties of cabbage juice. To any of these the University can offer a rich store of science and culture.

The pre-medical student may with profit, even in his earliest days, "walk the wards", following in the footsteps of his predecessors who learned so much by observing how the doctor approaches the patient and, even more important, how he leaves the patient. To Osler, in this country, we owe a debt to his insistence on bedside teaching, that osmotic process, so fundamental to the education of the doctor. I am sure I absorbed more medicine by contact with Osler, Sherrington, Cushing and Head than from all my formal courses in the medical school combined. Of some of them, no doubt painfully put together by conscientious men, I remember nothing, but I have little doubt that settled somewhere in my subconsciousness the essence of their devoted labors still resides. The effect may well be greater than we now realize for every impact of mind on mind affects our being. If Brown, however, will bring in the "outside breeze" from the hospitals and clinics and let it blow on its medically-minded undergraduates, the program you have in mind will be fully justified. There is no substitute for Mark Hopkins on the other end of the log.

Medicine, however, has long outgrown a Hopkins of any type. The ever broadening horizon is now beyond the sight of one individual. Specialism has become a necessity and the man who could write a text, with considerable completeness, even in his own field of endeavour, is rapidly vanishing from the medical world. Medicine must come, particularly to the recent graduate, by piecemeal, a nubbin here, a jot there. The intern or resident in any one of your many hospitals in Providence and its vicinity, could profit from the academic atmosphere, if a little more found its way into the wards, the laboratory and the deadhouse. If his body is not overworked, as so frequently becomes a necessity in a war-time environment, his mind is still plastic. Feed him, indeed, with a little of the basic diet of biology, physiology and chemistry and he will thrive, possibly beyond expectation.

Problem of Returning Soldier-Doctors

For the returning soldier-doctors, the diet must be more carefully ground. They are a sober, often badly shaken group. Many have seen God in their daily lives and have been deeply stirred by His proximity. For them, we need special handling, each man as a unit, and the Dean's pia mater may well be stretched to the near breaking point, before an individual problem is fully resolved. I hope we can avoid more "indoctrination", "refresher courses" and the grinding process of regimentation, so foreign to American life. A year of freedom, without restriction, in the University group, might be the best answer to the post-war educational problem of the returned soldiers. These men, above all, would profit by nourishment with sound scholarship of any type, particularly if there were added an ample sprinkling of the arts, to what, of necessity, they must acquire of the sciences.

The Opportunity Is At Hand

The practitioner, ever stretching his waking hours to fill the demands for his services, finds his few leisure moments unevenly spaced and often frequently interrupted. For him, I can only advise an occasional lecture, preferably by a visitor, sponsored by the University. If possible, have the distinguished guest 'in residence' for a few days, informally making the hospital rounds and dining with the doctors, students and internes. How much that is most influential in our lives, comes incidentally, as we move in and out among our fellowmen. Not all the principles on which are based our Hippocratic standards have come from the near

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THE CASH SICKNESS FUND

With more than a year's experience the State Cash Sickness Fund is now in a position to be more clearly evaluated as a factor in the social security program for the people of Rhode Island.

Recently the Unemployment Compensation Board administering the sickness fund reported that for a period of five months—April through August—the fund had paid out about one hundred thousand dollars more a month in benefits than it had taken in through payroll deductions in the same period. This announcement was followed by an editorial in the public press calling for an investigation and posing the question as to whether there might be "connivance between unscrupulous workers and doctors of easy conscience".

Since the public generally, to our best knowledge, thinks of doctors in terms of medical men, we naturally feel that we bear the brunt of any criticisms of certification for illness whereby benefits are gained through the State Sickness Fund. However, it should be carefully noted that the broadness of the definition in the Fund Act of sickness, and the too liberal attitude of the General Assembly through the years in allowing the title of Doctor to be used without any explanatory degree, permits anyone short of a doctor of philosophy to attest certification for workers' benefits.

Our leading newspaper calls editorially for an investigation, presumably only of the recent increase in expenditures for benefits. We call for a review of the entire program, possibly by such a group as the State Advisory Council on Health appointed by the Governor earlier this year. Such a review might well clarify the extent to which the people wish to compensate themselves for loss of employment due to sickness by a better interpretation of the definition of illness in this particular act. Such a review might establish a means by which the entire program may be more clearly interpreted to the people in terms of social protection. Such a review might better advise the General Assembly in its decision on amendments proposed by the administering board or other reputable authorities.

Basically the sickness act program is one of social relief and not of insurance, for too many incalculable variables constantly enter into the problem to make sickness determinable in advance. It is upon the law of probability of regular recurrence of events when great numbers of those events are considered that true insurance has its foundation. Thus, as Simons and Sinai have so aptly said, "In spite of the name and all that may be said to the contrary, the dominant motive in the establish-

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ment of every system of health or sickness insurance is the relief of poverty, not the preservation of the public health."

The medical profession of this State, however, has committed itself to the support of cash sickness compensation to offset the loss of income of the wage earner due to his illness. The State Medical Society has not been hesitant to point out what it considered faults in the administration of the act, and it created an Advisory Committee at the invitation of the Board to meet with it and discuss medical problems. But the sickness compensation program belongs to the people, not to the State, nor the medical profession, nor any other group licensed to practice the healing art. And to the people must be presented the complete problem.

There has been too little clear thinking on the distinction between the financial, economic, administrative and health phases of the act. As we have stated, the Fund is not aimed at the preservation of health. Yet it involves all those who profess to the healing art by reason of the certification of the sickness of the claimant. Thus the onus is placed upon the doctor who must not only fulfill his primary professional responsibility for adequate diagnosis and treatment of his patient, but who must also serve the State as a guardian of the financial status of the group.

As was pointed out in the report of the Committee on the Costs of Medical Care for the American People as far back as 1932, this situation "has been a major source of controversy, ineffectiveness, and sometimes of heightened costs" in foreign systems of health insurance. The insured individual naturally wishes a generous benefit in his particular case. Because sickness is not clearly definable by law, and as it is defined by insurance laws it is not identical with sickness as regulated by medical science, the doctor will naturally have a tendency to certify an applicant for cash benefits that may not be permitted under tightly construed legal qualifications.

Therefore, in not submerging his natural relationship to the patient so as to administer stringently the economic phases of the law the doctor by no means indicates opposition to the program, nor a lack of cooperation. He merely acts in time-honored manner, and as the people—his patients—require. He knows that any tendency to accede to the patient's demand for certification in excess of that which sound insurance law and a reasonable premium permit involves the necessity from the administrator's viewpoint of controls to protect the fund. He knows, too, that the problem of medical certification is inherent and must be dealt with so as to minimize difficulties.

The alarm that has been expressed at the increased payments for benefits in Rhode Island may or may not be justified. However, in the light of experience in Europe and in relatively small insurance projects in this country the situation is not unusual. On the contrary, Simons and Sinai point out in *The Way of Health Insurance* that "the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from seven to nine days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation of insurance."

If the Rhode Island program is to be successful it must be developed in the American way. The present period of trial and error is rapidly ending, and the time is opportune for a careful review. We all recognize the tremendous implications of a solvent Fund, and therefore we should welcome an actuarial study by experts to determine the future financial structure of the plan. Likewise, from a medical viewpoint a careful analysis is needed, for although the problem of certification would appear largely one of morale, there is vital need for education among the insured to help them realize the mutual character of the compensation program.

POST-WAR HOSPITAL PLANNING

Patients who depend upon the hospitals of Rhode Island for care, and physicians who depend upon them for hospitalization of their patients will be pleased by the trend of post-war planning by hospital administrators.

A questionnaire addressed to the administrators of all Rhode Island hospitals reveals several interesting and pertinent facts. Practically every hospital in the state is contemplating the addition of new buildings and facilities. Several have arrived at definite decisions and are actually having plans prepared. Many have estimated the cost of their proposed project and have reached a decision as to how it should be financed. One has nearly completed a fund raising campaign and will practically build a new hospital.

Among the new facilities contemplated are storage, housing, recreational and educational projects among the State Hospitals; additional children's and maternity wards, modernization of obsolete buildings, more surgical beds for women, more accommodations for the aged and more for maladjusted children.

It is impossible at the present time to give anything like an accurate forecast of the total cost of these projects, but it does not seem unreasonable to guess that 25 million dollars may be spent within

our state in the years following the war. This is a goodly sum and its expenditure for the health of our population will be of additional value in helping to reduce the possibility of a post-war depression. It will provide jobs for many people within our borders who now are working in essential war jobs.

These projects as they materialize will merit the support and encouragement of all Rhode Islanders.

AN EDUCATIONAL PROGRAM

The Committee on University, Hospital and Medical Society Relations which was appointed by the President of the Rhode Island Medical Society to work out a plan for improvement of local educational facilities for the physicians of the state has reported progress. There is published in this issue of the JOURNAL a list of specific proposals which have been accepted by the House of Delegates of the Society as a reasonable basis for future efforts. These proposals were previously discussed and approved by the Advisory Council, a group of physicians on which every county society and every hospital in the state has representation. As it is the expressed belief of the Committee that real educational advance in the state will be implemented principally through the efforts of the staffs of the various hospitals, advice, suggestions and critical discussion by such a representative group would seem to be the surest way for the Committee to keep its efforts limited to planning which is likely to be acceptable to the profession generally and to elicit its hearty cooperation.

Of the specific proposals advanced, the first two deal primarily with hospital organization. The first, which suggests that our hospitals reorganize their staffs with a view to improvement in rounds, meetings, conferences and the like, is appropriate even though in some local institutions excellent teaching programs are already in effect. Such institutions may well serve as models for others and members of their staffs as actual or potential consultants at hospitals with less well developed facilities can be of great help in bringing such hospitals up to a higher standard. The Committee has particularly stressed the suggestion that hospitals that are small and have limited facilities are perfectly justified in requiring that, to maintain a position as consultant, a physician must be willing to give a certain amount of time to the conducting of rounds and demonstration and in other ways participating in the educational exercises of the institution.

The proposal that definite increases in interne and resident staffs be made is theoretically excellent and is evidently aimed directly at the correction of the marked deficiency existing in Rhode Island hospitals that was pointed out by Dr. Reginald Fitz in the third Charles V. Chapin Oration. The difficulty is, of course, that no candidates for such positions are available; indeed all of our institutions are at present functioning as best they can either with marked curtailment of their peace time quotas of internes or, in many instances, with none at all. It is to be hoped, however, that the time is not too far distant when there will again be a number of recent graduates in medicine, many of them released from duty with the armed forces, whose professional development will demand the opportunities which our hospitals will be able to offer. It is certainly advisable to be prepared in advance.

The third proposal, that there be organized a Rhode Island Medical Society faculty to be available as requested to give lectures and demonstrations, clinical exercises and discussions of various sorts at hospitals and before county societies will be of value if sufficient demand for its services develops. Such a plan as carried out by the War Time Graduate Medical Meetings organization for the benefit of the physicians of the Army, Navy and Coast Guard in the New England area has been very successful. It is to be pointed out, however, that in this program attendance at meetings by medical officers is compulsory and therefore no instances of speakers finding themselves without audiences can occur—as was the case when, about 20 years ago, the Medical Society of this state undertook a similar plan.

The possible organization of a central institute of pathology, the study of which constitutes the fourth proposal of the Committee is a matter of considerable importance from the educational standpoint as well as from the point of view of the improvement of practical hospital routine. This idea aroused interest among the representatives of several of the smaller hospitals on the Advisory Council. The JOURNAL considers it a matter deserving special editorial comment which will be made at a later date as the development of further plans is announced.

As regards the proposal that Brown University be requested to offer clinical, laboratory and lecture courses open to members of the medical profession in Rhode Island, this idea appears to be quite in line with the plans already announced by the University as part of the program of its newly organized Department of Medical Sciences.

On the whole the report of the Committee amounts to the suggestion that the overworked members of our understaffed hospital organizations, adopting as a slogan "in time of war prepare for peace", pause long enough in their routine duties to develop plans for their respective institutions that will result in increased educational

continued on next page

opportunities for all their members and that will progressively develop with the return of peacetime conditions. After all the State Society cannot go much beyond the making of suggestions and it is, and it will be, up to the membership of the individual hospital and county society groups to do their own thinking and planning and to furnish the drive and enthusiasm which can bring the educational facilities of Rhode Island, and thereby the quality of medical service rendered to the citizens of our state, to a level of excellence which will not be surpassed elsewhere.

COMMUNITY EXPERIMENTS IN TOOTH DECAY

Dental history is apparently in the making as the experiment in the New York State communities of Newburgh and Kingston gets under way for a mass demonstration to test the theory that a minute amount of fluorine in drinking water is the way to banish tooth decay. Kingston will be the town with toothaches. Newburgh, not so far away, will be the favored city of the nation if the experiment is a successful one.

Fluorine, chemical sister of the chlorine that many communities put into their drinking water to purify it, has been in dental headlines on many occasions. As more and more evidence began piling up to show that a small amount of fluorine in the drinking water protected teeth from decay many persons thought that something should be done about the discovery.

The New York State department of health decided to initiate an experiment on a community scale. Newburgh's 30,000 citizens, already with some 0.12 parts per million of fluorine in their drinking water, will have the benefit of about 45 pounds of fluoride salt added to the three million gallons of water used daily. This addition will bring one part per million of fluorine in the water as it flows from every tap and faucet in Newburgh.

Since fluorine acts on the tooth structure during the years of tooth development, Newburgh's five to twelve-year-old children for the next ten years will have their teeth examined every year in the schools by the associate research dentist of the state health department. Similar examinations will be conducted in Kingston where the fluorine content of the water will not be increased, and the comparison of the dental statistical data will be looked to as the index of the practicability of mass protection in future years against tooth decay.

A CHILDREN'S HOSPITAL

The children's health facilities in Rhode Island have been the subject of considerable discussion during the past few years. An interesting but little publicized study of child health problems was conducted last year by the Health Division of the Providence Council of Social Agencies. In view of the augmented birth rate it was felt that an increase in illness among children would occur proportionate to the increase in child population.

The facilities for the acutely ill child, the orthopedic child, the child with heart disease, the tubercular child, the child with contagious disease, the mentally ill child, the diabetic child, the blind child and the hard of hearing child were studied for the purpose of determining their ability to absorb the inevitable increased demand. The conclusions are interesting in that they point out that the facilities for the acutely ill child at the present time are taxed almost to capacity and it is likely there will be a need for a larger number of beds for this type of illness within the next few years. There apparently is a definite need for a diagnostic and treatment institution for suspected or borderline psycho-neurotic and mal-adjusted children. The accommodations for the feebleminded at Exeter School are severely overtaxed. The problems involved in care of children convalescing with rheumatic heart disease are still to be solved. The needs of the other chronically ill children studied seemed to be adequate and no change appears necessary.

In any program which is aimed at solving the health needs of children the problem should be regarded in its overall aspect. If improvement is contemplated for our so-called chronic physical and mental disabilities it might be wise to discuss the advisability of setting up a distinct group of buildings or a distinct institution in some part of the State which would be used solely for children. It is obvious that many of these problems are interwoven, and it is possible that community health would be improved and administration simplified under such a program.

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DIAGNOSIS OF PEPTIC ULCER

continued from page 511

ics report that approximately 75 percent of ulcers in this area are cancer. The course of these lesions is somewhat harder to follow by x-ray than farther up the lesser curvature. Therefore, it seems wise to recommend surgery for the care of all lesions occurring within the first inch of the pylorus.

Virtually all ulcers on the greater curvature are malignant. This is true also of lesions on the posterior gastric wall. There is the occasional case in which it is difficult to determine whether the lesion originated on the lesser curvature or the posterior wall. Any element of doubt increases the possibility of malignancy.

Ulcers in the fundus may be either benign or malignant. With the present transthoracic surgical approach to the fundus, the decision of whether to operate may be difficult. In earlier days when we were loathe to attempt surgery in this part of the stomach, I have seen large craters come and go over long intervals, demonstrating the benignity of the lesion. Because surgery in this area is difficult, one does not like to advise it unnecessarily. Therefore, one prefers to diagnose the nature of the lesion by its response to medical therapy.

Approximately 95 percent of the ulcers encountered on the lesser curvature are benign. The malignant cases can be usually distinguished by a combination of careful roentgen observations, gastroscopy and the response of the lesion to therapy.

X-Ray Findings: A roentgen study should note the location, the size of the crater, whether or not a rim can be seen about the lesion and the presence or absence of induration about the crater and whether peristalsis travels through the area. Most benign ulcers have a diameter of less than 2 cm.; whereas, many malignant lesions are more than 4 cm. across. Although a diagnosis cannot be made on size alone, it is generally true that the larger the crater the more likely it is to be malignant.

The appearance of the gastric wall immediately adjacent to the crater is important. A benign ulcer is a punched out affair with little or no involvement of the surrounding tissues. At most, there will be only some thickening or induration of the wall. Therefore, the radiograph reveals the surrounding tissue to be smooth. A malignant lesion is usually a tumor with an ulcer in its center, which may give rise to a rather characteristic contour about the ulcer. Pressure exerted over the area will reveal a rim about the crater as a result of the tumor impinging on the lumen of the stomach. This may have a rough, irregular or slightly beaded appearance. The spot film device of modern x-ray outfits aids tremendously in bringing out this appearance. The wall of the stomach surrounding a malignant lesion is prone to show a concave deformity which does not occur with a benign ulcer.

A benign lesion may show the rugae radiating into the crater, a finding which is not observed in a cancerous lesion. Peristalsis is more prone to traverse a benign than a malignant lesion. The presence of these points has more diagnostic value than their absence because the best apparatus and the most skilled roentgenologist cannot always demonstrate them even though present.

Gastroscopic Studies: Direct visualization through the gastroscope is another method of obtaining the same information. It may be useful in providing evidence which the x-ray cannot give.

Response to Treatment: Response of the lesion to treatment is an important diagnostic aid. Usually a prompt response indicates a benign lesion; whereas, a questionable to slow response suggests a malignant condition. Although variations occur in both directions, some criteria for the rate of healing must be established if response to treatment is to be used as a diagnostic aid. Experience reveals that most benign lesions respond to intensive medical therapy in the following way: On complete bed rest, bland diet, and complete neutralization of the gastric acidity, the lesion should shrink 50 percent in size within ten days to two weeks. Healing may be slower after this, but should continue as observed at 2-3 week intervals by the x-ray. If progressive healing is taking place one may justifiably continue medical treatment for 6-8 weeks. If the crater has not completely disappeared by 8 weeks it is best to advise surgery. By following this rule, few malignant lesions will be missed, but such a program requires that the patient be observed continuously for 8 weeks or until the lesion has entirely disappeared. It is not safe to discharge a patient because the crater has become infinitesimal. IT MUST DISAPPEAR ENTIRELY.

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ORAL PATHOLOGY

An analytical review by NICHOLAS G. MIGLIACCIO, D.M.D., *of Providence, of Dr. Kurt Thoma's second edition of "Oral Pathology"*

(It has never been the policy of the Journal to publish lengthy reviews of scientific texts. An exception is made in this instance in view of the brilliant analysis by Dr. Migliaccio which cannot fail to provide interesting and vital data for every doctor. The Editors)

Once again the dental profession is indebted to Dr. Kurt Thoma for his new second edition of "Oral Pathology." Extensive revisions and changes in this edition have helped to broaden the advancement in this limited field. The book covers the histologic study of oral disease and endeavors to correlate the microscopic picture with the roentgen and clinical findings. Diseases of the jaw and oral mucosa are covered from their inception to their termination in a clear and descriptive manner.

Dr. Thoma has maintained his Table of Contents in such a manner that it is similar to an encyclopedia, with each minute topic completely covered and with its page number included.

The beginning of the book is taken up with a section on Experimental Pathology, then in order: Developmental Anomalies of Teeth; Developmental Anomalies of the Head; Functional Changes of the Teeth; Traumatic Injuries of Teeth; Odontitis; Periodontal Diseases; Extension of Odontogenic Infection; Diseases of the Jaws; Tumors of the Jaws and Oral Mucosa; Diseases of the Oral Mucosa, Lip and Tongue; and Diseases of the Salivary and Mucous Glands.

Dr. Thoma's excellent illustrative matter is both outstanding and remarkable. The clear well-selected photographs, combined with complete descriptions result in logical diagnosis and therapy.

The clearly detailed black and white photographs number about one thousand two hundred and sixty, covering each subject that Dr. Thoma discusses fully. The photographs are all of great value, but there were a few that interested me especially.

Sulpha drugs have been used extensively but very little is known about their allergic tendencies. Dr. Thoma already has a black and white photograph showing the oral manifestations of allergy to sulpha drugs. This photograph was taken by Klatell in 1943 and shows the following manifestations of Allergy to sulfanilamide: small papules on the tongue, lips, cheeks or palate, and occasionally on the gingiva.

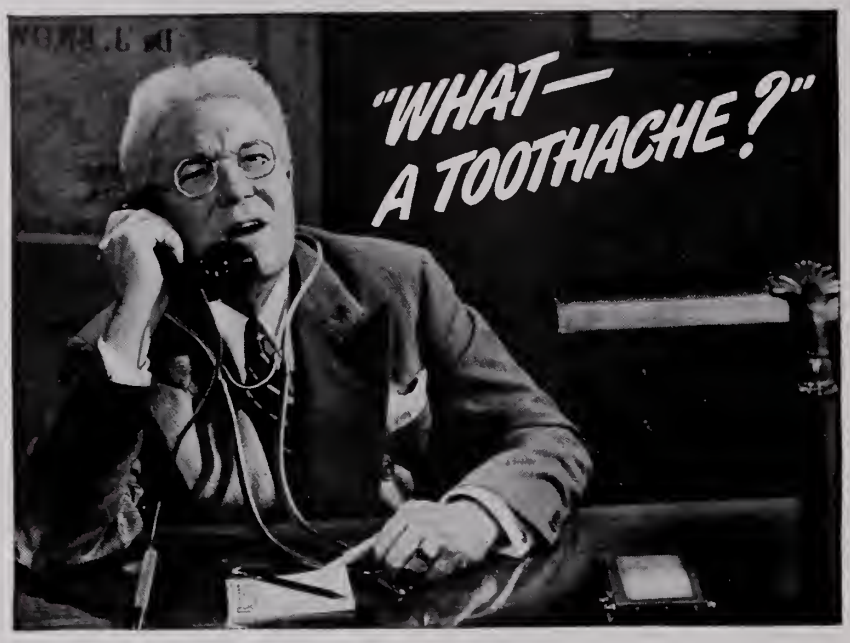
Another photograph that impressed me was the one on Galvanism. Galvanism is caused by a galvanic current generated in the oral cavity causing a denuded patch on the tongue. A photomicrograph of the galvanism contained metallic deposits in the epithelium.

A very interesting group of pictures are those showing the effect many years of smoking has in the mouth. This is known as Stomatitis Nicotina and affects especially individuals with fair and sun-sensitive skins.

Color aids in the recognition of oral diseases, particularly diseases of the oral mucosa and salivary glands. The colored illustrations in this second edition are more numerous than in the first edition, and here the author really accomplishes a new high in colored photography. Any general practioner in dentistry, with the aid of these colored illustrations, can very easily compare them with the conditions prevailing in the mouth and an accurate diagnosis can be made practically every time.

One of the colored photographs showed a burn from an asprin tablet caused by placing it on the gingiva. The photograph shows a whitish wrinkled area. The asprin had destroyed the epithelium over a wide area. This case was of particular inter-

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ORAL PATHOLOGY

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est because, today, a great deal of pain relieving drugs are used in the mouth. Another reason why this illustration is of particular interest, is because it definitely shows the reaction caused by asprin. A patient I have seen at the Tumor Clinic showed a similar reaction which completely disappeared within two weeks after discontinuance of asprin.

Another well illustrated colored picture is hypertrophic gingivitis due to use of dilantin which shows a marked overgrowth of the gingiva with an enlargement of the interdental papillae and finally involved the entire gingival margin. The teeth appear to be buried in the hyper-plastic tissue which has a firm consistency and does not bleed easily.

The group of colored plates on Vincent's Infection or Trench Mouth show different stages in the development of Vincent's Infection from a very mild case to a severe case that develops into Noma. The pictures show the gingiva markedly inflamed with grayish ulcers in the interproximal spaces, and these ulcers form a continuous slough. The gingival margin is separated from the teeth causing deep destruction and loosening of the teeth. The surface is very tender and painful and bleeds very readily. The illustration on Noma shows a brownish slough and large gangrenous area which usually ends fatally.

The next few paragraphs will be taken up with a brief resume of the new features found in this second edition.

Relation of hormones to vitamins

The problem of a potential connection between the hyperkeratinization of oral mucous membranes seen in Vitamin A deficiency and that produced in long-term large dose estrogenic therapy has been investigated by Ziskin et al (1943). They state that hormones and vitamins have specific effects on the organism as a whole. Both substances affect epithelial structures in a definite manner.

Idiopathic resorption of the tooth

Idiopathic resorption of the tooth, also described as internal resorption, is a topic of great interest just now because the conditions have been increasing in recent years. The etiology of this disease is unknown, and there have been a great many theories concerning its cause. Mummery (1920) believes that it is due to chronic pulpitis and that the resorption starts from within the tooth. Euler (1929) states that granulation enters through the apical foramen causing the resorption. Coyer and Sprawson (1931) have shown that the infection may originate from periodontal diseases and enter tooth through accessory canals. Many cases have been reported where the resorption starts from without and this is known as Peripheral Resorption. X-rays show that the necks of these teeth has a dark area where the resorption has taken place. This seems to involve the pulp canal. Dr. Thoma has a series of x-rays that prove both the internal and external theory of absorption. These x-rays show the damage that has been done to the dentine of the teeth and seem to involve the pulp and are a great aid in diagnosing the condition. Photomicrographs show the evidence of the resorption process. They also show resorptive channels and evidence of hyperemia and abscess formation in the pulp. The treatment of all types of resorption depend upon the limit of damage done; extirpation of the pulp, root filling, or loss of teeth and proper replacements made.

Eosinophilic granuloma

Eosinophilic granuloma occurs in children, causing tumorlike destructive swellings of the bone. It may be accompanied with lowgrade fever, leucocytosis and blood smears showing eosinophilia. When the jaws are affected the teeth become irregular, loose and may be exfoliated. The osteolytic process is best shown by x-ray, where large areas of bone were destroyed. Examination of the tissue from the mandible show mononuclear eosinophiles. The lesions were treated with x-ray therapy, and pituitrin was found to control the accompanying diabetes insipidus.

Abscesses and phlegmous resulting from odontogenic infection

In odontogenic infection, Dr. Thoma has revised and enlarged the whole subject and brought it completely up to date. Odontogenic infection, including the teeth and jaws is not to be considered of local nature. This presents a medicodental problem that should receive the careful attention of both the physician and dentist. Osborne, Professor of Therapeutics, at Yale University, in a monograph

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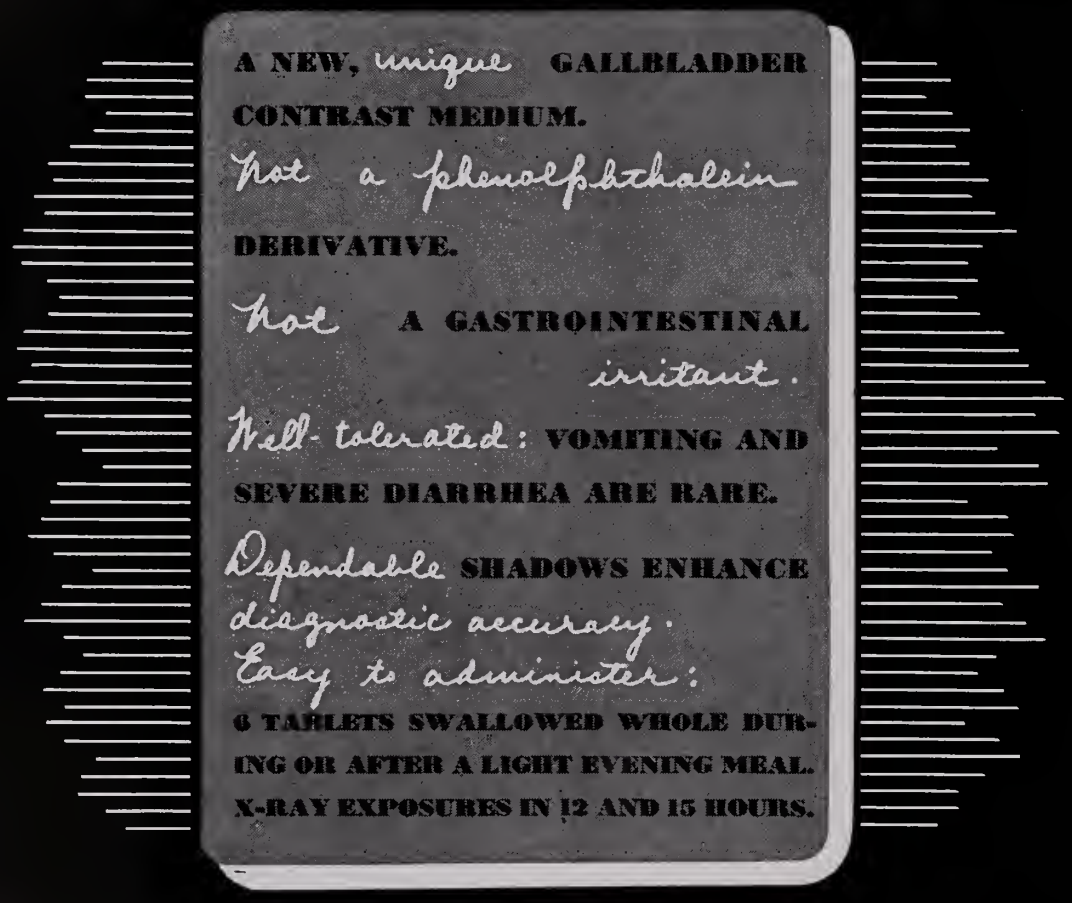
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MEDICAL RECORDS IN THE HOSPITAL

MARY NUNEZ, *Record Librarian*
The Memorial Hospital, Pawtucket

ANY discussion about hospital case records must necessarily be prefaced by an explanation of the reason why hospitals keep complete case reports, and why such reports are of vital importance.

First, what is the hospital record composed of? When a patient is admitted to the hospital, the hospital record is begun by the admitting officer, who obtains the admission record. This includes the patient's hospital number, name, address, doctor, location in hospital, admission date, age, marital status, religion, occupation and the name and address, telephone number of a relative or other interested person. This information is important. For example, if a patient is on the danger list, or is to be operated on, relatives wish to be notified and a Catholic patient may want to see a priest. Also, this information may be necessary at a later date in properly identifying the patient. This is especially helpful when you have people by the same name such as Smith, Brown, Jones, etc.

Bedside Notes

After the patient is admitted to the ward, it is the responsibility of the nursing force to enter the temperature, pulse and respiration reports in a graphic chart and keep bedside notes of her observations and care given to the patient. The doctor depends on the nurse's part of the record for the detailed knowledge of the results of treatment he has ordered. In these bedside notes, the nurse stresses her observations of the patient, medication given, diet, etc. Some of these notes may be of the character of the sleep and its effect on the patient's condition, whether it relieved the symptoms; the description of pulse, whether weak, irregular, thready, etc.; if the patient has a cough, whether it is dry or moist, accompanied by pain, or any other observations pertaining to the patient's condition. The more definite and complete her statements the more value the hospital record will have to the doctor. These bedside notes are signed by the nurse in attendance and usually checked by the supervising nurse.

A special sheet is provided for recording the treatment ordered by the doctor and this is kept from the time of admission of the patient to the hospital until discharge.

History

The attending physician is responsible for the history of a patient or he may delegate an interne. The doctor is required to sign his approval of the contents. He is also responsible for progress notes upon the case and the writing and signing of orders for treatment. Due to the shortage of doctors and internes brought on by the war, at the present time, a properly qualified nurse is taking histories on ward patients at the Memorial Hospital.

When obtaining a history, the following outline is usually followed by the doctor or nurse historian when interviewing the patient or in case the patient is too ill, the nearest relative or interested person:

1. *CHIEF COMPLAINT* or the outstanding symptom or symptoms of the patient.

2. *FAMILY HISTORY*—the amount and character of the information depends on the type of case and although to the patient, the questions may seem foolish, they are really very important. The doctor may inquire as to whether the patient has living parents, brothers, sisters, husband or wife. If so, what are their ages and present state of health? If dead, what were their ages and causes of death. Nationality of parents may be important as children of parents born in foreign countries may be suffering from a nervous disorder because of the conflict in the home and social life. The family history of familial diseases such as tuberculosis,

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HOSPITAL MEDICAL RECORDS

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"bleeder's disease," cancer, insanity, etc. is obtained. While inheritance of disease is very rare, predisposition is very common. Family history of contact with tuberculosis may be important to the doctor and the proper treatment of the patient.

3. *PAST HISTORY*—information obtained includes birth history, early diseases, diseases and operations of adult life, menstrual and obstetrical history in women, habits, environment, personality and adjustment. Doctors find this information very important in the diagnosing and treatment of the case. Certain diseases may be clues to the doctor in making his diagnosis.

4. *PRESENT ILLNESS*—this is a story of the patient's illness and the amount of information obtained will depend upon the nature of the case. For example, in cases of accidental injury, the history will be much briefer than when a patient is admitted with a longstanding chronic disease.

A carefully taken and recorded history will aid the doctor in making the diagnosis of his case and will prove valuable in medical research and study of cases.

Following the recording of the history of the patient, the physical examination is recorded by the doctor or interne and his findings dictated to the record librarian or written by him in longhand. Record librarians are taught medical terminology so that they may aid the doctor in keeping proper hospital records.

Special Reports

During the patient's hospital stay, records of laboratory tests, x-rays, operations, consultations, electrocardiographs, special examinations by the responsible parties are incorporated in the hospital case record. In case of death, if an autopsy is performed, a detailed report of the autopsy findings is included in the record and may prove very valuable in accident cases or medical research.

On discharge of the patient, the final diagnosis and condition on discharge are included in the record and the signature of the attending doctor approving the contents of the hospital record is necessary before filing.

After the patient is discharged, the record is sent from the various wards to the record department where it is checked for completeness. When the nurses and the doctors have completed their part of the record, and it is ready for filing, the record office indexes these records according to name, disease, complications and operation. I have brought some of these cards to show you. Then the record is placed in a folder and filed numerically. The name index is in an alphabetical file and enables the record librarian to find the patient's record. The disease and complication index separates the cases according to disease and are filed according to a standardized code. In this way, records are easily produced when a doctor wishes to study cases with a particular disease. The operation index is kept in similar manner as the disease index excepting that it deals with operations.

The American College of Surgeons have set a standard for hospital records and if a hospital fails to measure up to this standard, it does not receive its highest rating.

Hospital records are kept in order to properly treat the patient while in the hospital and after discharge from the hospital for various other reasons. The record is of value to the patient. A patient who is treated and goes away, usually returns to be treated either in the same institution, or in another, or at his home. If he returns to the same hospital, the record department produces promptly the chart on his first admission. This information may be very valuable if the patient goes to another hospital. Upon request a resume of his hospital record will be sent and this will assist in handling his case successfully.

These records may be valuable as legal evidence. They are frequently called into court on compensation cases and in accident cases in which damages are claimed. Questionnaires and requests for information from all sorts of public health agencies for statistics constantly are received by the head of every hospital. They are used by medical men who write for publication or teach, or at medical meetings and conferences.

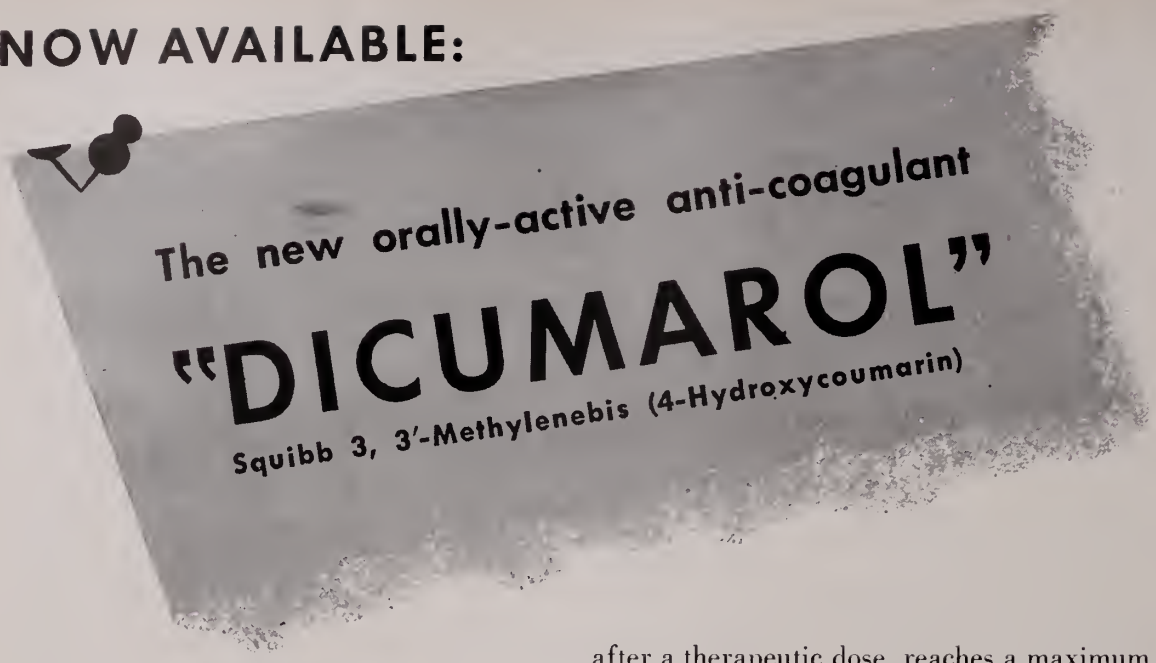
Therefore, it is necessary that the medical record department check, assemble, analyze, index and file these case charts. These are the duties of the record librarian and members of her department. Also, the record department makes case summaries, answers inquiries, and does statistical work for the doctors and hospital.

Record librarians are taught to keep all information regarding patients confidential and follow definite rules when giving out any information regarding a patient's record.

The Accident, Out Patient, Social Service, X-ray, Laboratory, Photographic and other hospital departments keep records of the work done in their respective department and these records are of great importance, also.

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"Dicumarol" has been used alone or as an adjunct to Heparin in the treatment of postoperative thrombophlebitis and pulmonary embolism, acute embolic and thrombotic occlusion of peripheral arteries, recurrent idiopathic thrombophlebitis, post-traumatic and post-infectious thrombophlebitis, and pulmonary embolism. The drug should not be used until the physician has fully familiarized himself with its physiologic properties, contra-indications, and the various precautions to be observed in its use.

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* "Dicumarol" (Reg. U. S. Pat. Off.) is a registered collective trade-mark of the Wisconsin Alumni Research Foundation.

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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on September 28, 1944

WILLIAM P. BUFFUM, M.D., *Secretary*

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Thursday, September 28, 1944.

The following members were in attendance: Rocco Abbate, M.D.; Joseph L. Turner, M.D.; Emery M. Porter, M.D.; Henry E. Utter, M.D.; George W. Davis, M.D.; James H. Fagan, M.D.; Raymond F. Hacking, M.D.; Ralph Di Leone, M.D.; Joseph B. Webber, M.D.; Robert H. Whitmarsh, M.D.; Joseph L. Belliotti, M.D.; George W. Waterman, M.D.; Jerome J. McCaffrey, M.D.; Frank W. Dimmitt, M.D.; Louis A. Sage, M.D.; Gordon J. McCurdy, M.D.; Bertram H. Buxton, M.D.; Harold G. Calder, M.D.; A. Henry Fox, M.D.; Arcadie Giura, M.D.; Julianna R. Tatum, M.D.; Elihu S. Wing, M.D. and William P. Buffum, M.D.

The Secretary reported that the minutes of the last meeting of the House of Delegates had been published in the MEDICAL JOURNAL and therefore he recommended that the reading of them at this meeting be omitted. The action was approved.

The Secretary reported as follows on the actions of the Council of the Society at its meetings since the last session of the House:

Meetings of the Council were held on July 19 and September 20. In addition to recommendations which will be considered separately by the House of Delegates at this session, the following important actions were taken by the Council since the last meeting of this House:

The names of Dr. Paul E. Boucher of Woonsocket and Dr. Fidele U. Luongo of Providence were approved for submittance to the State Director of Health as nominees to fill the vacancies on the State Board of Examiners in Chiropractic.

Approval was given of the nomination of Dr. John E. Donley of Providence as Director of the State Curative Center, and of Drs. Edward A. McLaughlin, Albert H. Jackvony, and Arthur H. Ruggles as members of the Advisory Board.

Referred to the Committee on Public Health was the request of the State Board for Vocational Education for a medical advisory committee, with authorization to the Committee on Public Health to act with power in selecting a committee to assist in the program and at the same time to coordinate into this rehabilitation group in so far as possible the advisory board to the Curative Center.

Received with approval and referred to the Committee on Arrangements the report of the sub-committee on Exhibits in connection with the Annual Meeting in which a net profit to the Society of $876.30 was listed.

Approved of the plan of a public poll regarding voluntarly surgical insurance and authorized the Treasurer to pay up to $65.00 for the expenses incurred in conducting the survey.

Approved of the naming of the new Committee on medical education, the "Committee on Hospital, University and Medical Society Relations" in order to avoid conflict in titles with the Society's committee on Medical Education already existing for other phases of the work.

Approved of the appointment by the President of Dr. Peter F. Harrington to serve as the Society's representative on the Governor's executive committee for outlining the Veteran Rehabilitation and Reemployment Program.

Moved that Society be recorded as being of the opinion that medical supervision should be available at high school athletic contests, and that in view of the demands upon the doctors in active practice at this time every effort should be made to secure the services of interns or residents of hospitals for the actual playing time of such contests.

Approved of the proposal to secure opinions from all members of the Society serving with the armed forces relative to post-war medical education, such information to be utilized by the Committee on University, Hospital and Medical Society Relations for the planning of its programs.

Approved of a proposed budget submitted by the Treasurer for 1945.

Recommended that the Trustees initiate legal action to clarify the disposition of the Fiske Fund.

Dr. John E. Donley, newly-appointed director of the State Curative Center, reported on the formation of that organization. He read extracts from the General Laws creating the Curative Center and he explained how the Advisory Board appointed with the consent of the Rhode Island Medical Society was now working on plans of operation. He also explained briefly the purposes of the Center and the methods of procedure by which the work will be carried forward. The matter was briefly discussed by members of the House.

Dr. B. Earl Clarke reported for Dr. Alex M. Burgess, Chairman of the Committee on University, Hospital and Medical Society Relations. Following the presentation of this report Dr. Emery

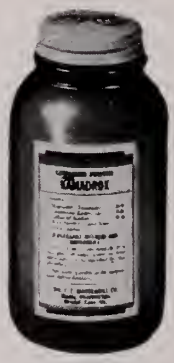
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HOUSE OF DELEGATES REPORT

continued from page 529

M. Porter moved for the approval of the House of the plan outlined by the Committee so far and for the continuance of the Committee work. The motion was unanimously voted.

Dr. Jesse P. Eddy, Chairman of the Committee on Medical Education, reported on the new dramatized radio program sponsored by Blanding & Blanding in Providence. He explained that a doctor from the Rhode Island Medical Society would be invited each week to conclude the program with a three minute dialogue regarding some important phase of health. He stated that he did not believe that the program would be successful without the use of the doctor's name, and since it has been the policy to publicize the doctor on the State Society program and on national programs he recommended that similar action be taken with this new program by Blanding's. The matter was discussed by the members of the House, after which Dr. Frank W. Dimmitt moved that the House give approval of the use of the doctor's name on the radio program sponsored by Blanding & Blanding. The motion was seconded and passed.

The President notified the House that he was appointing Dr. Robert Henry of Pawtucket as member at large of the Board of Trustees in accordance with the regulations of the By-Laws.

In the absence of the Treasurer and the Assistant Treasurer Dr. William P. Buffum, Secretary, read the proposed budget for 1945 as approved and submitted to the House by the Council. Dr. Joseph Belliotti moved the approval of the House of this budget. The motion was seconded and passed.

Dr. William P. Buffum submitted the following recommendation of the Council relative to the assessment of dues for 1945:

To meet the proposed budget the Council recommends to the House that the Annual dues for 1945 be set at $15 per member, plus a special tax of $10 per member to compensate for the loss of income due to the exemption from all assessments of members with the armed forces. The Council also recommends that the entire assessment be made on or before January 1, 1945.

Dr. Emery M. Porter moved the adoption of the recommendation of the Council regarding the assessments for 1945. The motion was seconded and passed.

The Secretary presented the following recommendation of the Council regarding the Annual Meeting for 1945:

The Council recommends to the House that the Annual Meeting of the Society in 1945 be held on Wednesday, May 16 and on Thursday, May 17, at Providence, and the Council further recommends that the Committee on Arrangements be authorized to investigate the possibility of holding the sessions at a local hotel.

Dr. Robert H. Whitmarsh moved the adoption by the House of this recommendation. The motion was seconded and passed.

Dr. Elihu S. Wing briefly reviewed the problem of medical certification for heavy cream and he called upon the Executive Secretary to explain the developments which have occurred since the War Food Administration regulations were revised on August 1. Mr. Farrell outlined the action of the Medical Society in the matter and also reviewed the procedure that is being followed in neighboring states where certification of cream has been eliminated by action of the medical societies.

The Secretary presented the following recommendation adopted by the Council:

The Council recommends to the House that it be the expressed opinion of Society that 19% cream fulfills all the necessities for cream in medical practice, and that all requests of butterfat in excess of 19% should be denied.

The Secretary posed the question as to whether this recommendation should be extended to provide for certification for any exceptional cases. After a brief discussion the opinion was expressed that there should be no exception. Therefore a motion was made that the recommendation of the Council be adopted by the House. The motion was seconded and passed. The President suggested that the Ex-

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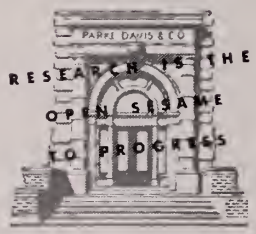
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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., *Chairman*; Stanley Davies, M.D.; Arthur E. Martin, M.D., Elihu S. Wing, M.D., William P. Buffum, M.D.

INDUSTRIAL NURSING MEMBERSHIP DRIVE

The American Association of Industrial Nurses started on October 1, a drive for new members. This national association was organized in 1942 in recognition of the growth and expansion in the field of industrial nursing.

Though the war has brought an extraordinary growth in this area, some of which will be cut as war industries close, industrial nursing is now established as an important and permanent branch of nursing.

Industrial nursing is an integral part of the growing movement to provide safety and health to our great worker population. This movement, instigated privately by industrial management, and officially by city, state and federal governments, is a substantial and growing phase in our country's efforts to prevent accident and disease and to promote health.

The AAIN represents nurses in every field of industrial and mercantile establishments. Its governing board is representative of the country as a whole. Its membership requirements are on a par with those of other standard making nursing bodies. It has already made material progress through the appointment of an executive secretary, in appointing counsellors in strategic areas for advising nurses, and in laying the ground-work for university and college courses in industrial nursing. Its expanding action program is centered on a sharing of common problems by all nurses in industry, and in aiding these nurses to broaden their usefulness to society.

The AAIN actively encourages membership in the nursing profession's official bodies, the district, state and national nurses associations. It also encourages the creation of sections on industrial nursing within these bodies, and it works in close harmony with these and all other agencies concerned with industrial and community health.

In this drive the American Association of Industrial Nurses appeals to industrial management, physicians and safety engineers, as well as to nurses, to bring word of this association to their nurses. A post card inquiry will at once furnish complete information to a prospective member. Address Mrs. Gladys Dundore, RN, Executive Secretary, 54 West 10th Street, New York City 11, N. Y.

INDUSTRIAL LUNCHES

Probably the most important item in the worker's day is his lunch. Too often his lunch consists of left-overs from meals at home. It is not prepared with any great care or foresight. It represents merely a stop-gap in the day's work and does not evoke time, effort, or a great deal of consideration from the average housewife who prepares the lunch.

Any solution to this difficulty should be indeed welcome. A novel scheme to meet the needs of the worker and correct the improper lunch box, is sponsored by the Pawtucket Nutrition Committee, Office of Civilian Defense, of which Mrs. Alice E. Kirwin is Chairman. The committee is sponsoring a "Lunch Bag". The lunch, which sells for twenty-five cents, consists of one sandwich, a piece of fruit and a sweet — such as blueberry cupcake, a brownie, etc. The lunch bags are put up at "The Sandwich Shop" in down town Pawtucket. Deliveries are made by the owner of The Sandwich Shop to the plant at specified hours to meet the change of shift or rest period — 9:00 A. M., 10:00 A. M., 6:00 P. M., 11:30 P. M., etc.

It has been found that a high percentage of the sales are to women workers, housewives who do not have time to shop or put up lunches, and also to very young girls who just do not bother to take a lunch. To date lunches have been sent to twenty different concerns and more requests are coming in. One concern has now asked the "Lunch Bag" to supply coffee in addition to the balanced lunch.

It would seem that this proposition bears considerable watching and might be instituted in other communities.

We have come to realize that there are more people employed in small plants than in large ones. A study reveals 301 firms employing 100 or more, and 3,000 firms employing from 3 to 99 workers. The total number in the first group was 106,900 and in the smaller plants 124,800.

In Rhode Island the major part of the problem for providing adequate food for workers is the field of the small industry. Those physicians and personnel men in small industries would do well to consider supporting similar lunch arrangements.



HEROES... Behind Masks

BOMBS screaming down . . . shells crashing . . . the crazy chatter of strafing planes' machine guns . . . they're the "background music" of the drama that's played on every fighting front every day by the surgeons of the field clearing-stations.

"Soldiers in white". . . heroes—behind masks.

Naturally we are proud that their choice of a cigarette—in those moments when there's a brief respite for a heartening smoke—is likely to be Camel. The milder, rich, full-flavored brand favored in the Armed Forces all over the world.

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Rhode Island Medical Society

(As of October 1, 1944)

(*Indicates member in service with the armed forces of the United States)

(†Indicates Associate Member of the Providence Medical Association)

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*Allen, Reginald A.
*Allen, Richard E.
Allin, Francis E.
Alston, James A.
*Angelone, C. Thomas
Angeloni, Tito
Appleton, Paul
Archetto, Angelo
*Arciero, Michael
*Arlen, Richard S.
Armington, Herbert H.
Ashworth, Charles J.
Astle, Christopher J.

*Baldridge, Robert R.
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*Barrett, Harold S.
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*Batchelder, Walter
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*Beck, Irving A.
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Bellano, George W.
Bellino, Antonio
Belliotti, Joseph L.
Benjamin, Emanuel W.
Bennett, Lewis T.
Bernado, John R.
*Bernasconi, Ezio
Bernstein, Perry
*Berrillo, Anacleto
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*Bishop, E. Wade
Black, Edward J.
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Blount, Samuel G.
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*Botvin, Morris
*Boucher, Reginald H.
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Bradshaw, Arthur B.
*Bray, Russell S.
Breslin, Robert H.
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*Brown, Abe A.
Bruno, Paul C.
*Bryan, Charles E.
Buffum, William P.
Burgess, Alex M.
*Burgess, Alex M., Jr.
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Burling, Temple
Burns, Francis L.
*Burns, Frederic J.
Burns, Louis E.
Burrows, Ernest A.
*Burton, Kenneth G.
Butler, William J.
Buxton, Bertram H.

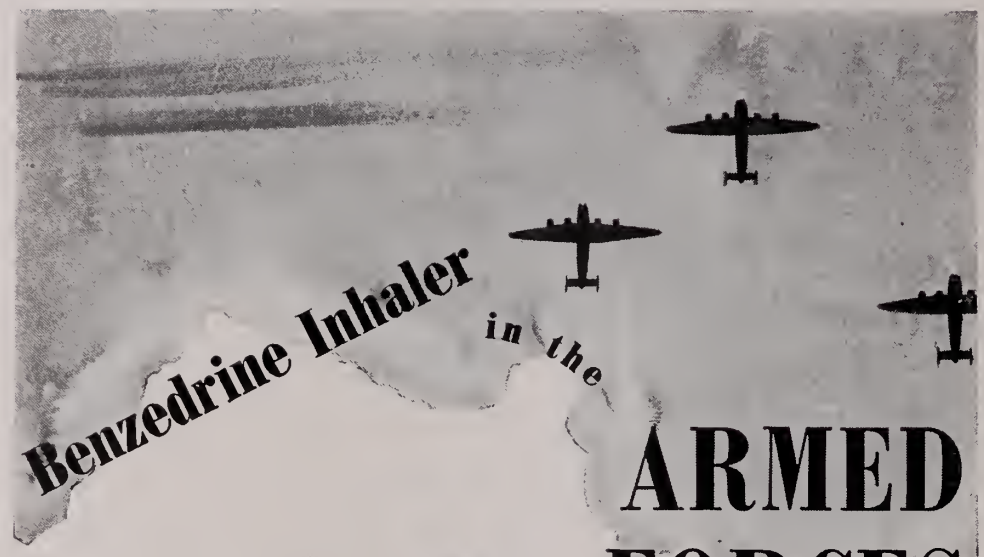
Caldarone, Alfred A.
Calder, Harold G.
Calise, Domenico
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Campbell, Edward
Capobianco, Giovanni
Capwell, Remington P.
*Cardi, Alphonse R.
*Carroll, Robert E.
*Case, Jarvis D.
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Castronovo, Joseph
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*Curren, L. Addison
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Cutts, Katharine K.
*Cutts, Morgan

*Damarjian, Edward
*Darrah, Harry E.
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*Davis, William P.
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DeFusco, Bruno G.
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Devere, Frederick H.
DeWolf, Halsey
DiLeone, Ralph
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*DiPippo, Palmino
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Dougherty, Edward F.
Dowling, Joseph L.
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D'Ugo, William P.
Durkin, Walter R.
Dustin, Cecil C.
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Eddy, Jesse P., 3rd
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Eliot, Alice M. B.

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Fain, William
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*Feinberg, Banice
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Field, Eugene A.
*Fish, David J.
Fish, Vera J.
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Fletcher, William
*Flynn, Joseph C.
Fogarty, Thomas F.
Foley, William H.
Forget, Ulysse
*Fortunato, Stephen J.
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Fox, G. Raymond
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continued on page 537



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*Gibson, J. Merrill
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Giura, Arcadie
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Hammond, Roland
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Happ, Linley C.
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Harvey, N. Darrell
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Hill, Prescott T.
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*Hogan, John P.
Honan, Frank J.
Horan, William A.
Houghton, Montafix W.
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*Hubbard, John D.
*Hughes, William N.
Hunt, Russell R.
Hyer, Harrison F.
Iavazzo Anthony A.
Indeglia Pasquale V.

Jackvony, Albert H.
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Johnston, Joseph C.
Jones, Henry A.
*Jones, Walter S.
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Jordan, William H.
Joyce, Henry S.

Kapnick, Israel
*Kay, Maurice N.
Kechijian Harry M.
Keefe, Howard F.
Kelley, Jacob S.
*Kempker, Adele C.
Kenney, John F.
Kennon, Charles E. V.
*Keohane, John T.
*Kiene, Hugh E.
Kingman, Lucius C.
Kirk, George E.
Kraemer, Richard J.
*Korb, Milton
Kramer, Louis I.

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*Leet, William L.
Lenzer, Simon G.
Levy, William S.
Libby, Harold
*Lippitt, Louis D.
Lisbon, Wallace
*Litchman, David
*Littlefield, Frank B.
*Londergan, James P.
Lord, Robert M.
Luongo, Fidele U.

MacCardell, Frank C.
Magill, William H.
Mahoney, Andrew W.
*Mahoney, William A.
Malinou, Nathaniel J.
Mandell, Israel
Margossian, Arshag D.
Martin, Arthur E.
Martineau, Laurence A.
Marzilli, Alexander F.
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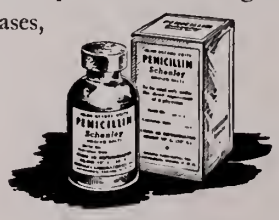
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of *Rhode Island Medical Journal*, published monthly at Providence, Rhode Island, for October, 1944.

State of Rhode Island } ss.
County of Providence }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Peter Pineo Chase, M.D., who, having been duly sworn according to law, deposes and says that he is the Editor-in-Chief of the *Rhode Island Medical Journal* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Act of March 3, 1933, embodied in section 537, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Rhode Island Medical Society, 106 Francis Street, Providence, R. I.; Editor, Peter Pineo Chase, M.D., 106 Francis Street; Managing Editor, John E. Farrell, 106 Francis Street, Providence, R. I.

2. That the owner is Rhode Island Medical Society, 106 Francis Street.

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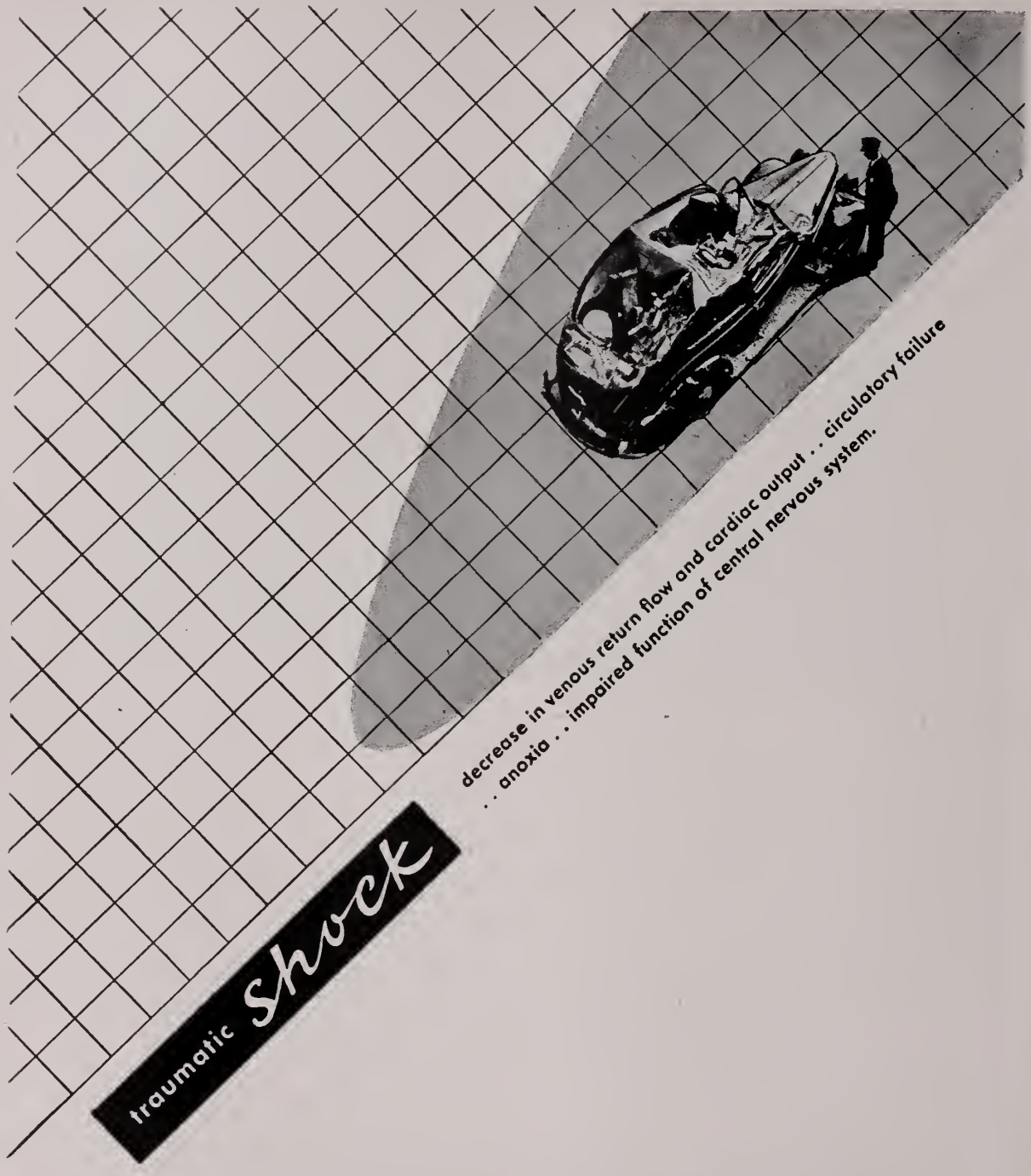
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continued from page 519

The differentiation of a benign ulcer from a carcinoma of the duodenum

Carcinoma of the pancreas which invades the duodenum may produce a radiographic appearance indistinguishable from ulcer. The symptoms which cause the patient to seek help may be any one or a combination of gastric retention, bleeding and jaundice.

The diagnosis is made on the patient's age, absence of typical ulcer symptoms and other findings indicative of carcinoma of the pancreas.

The condition occurs in the latter half of life and the older the patient the more seriously it must be considered.

I have never seen a case which presented the typical symptoms of ulcer. However, it is true that one sometimes encounters elderly patients with a cicatrized duodenal ulcer which has produced gastric obstruction without typical symptoms. Therefore, the absence of typical symptoms does not eliminate ulcer as a possibility; whereas, their presence virtually rules out a carcinoma of the duodenum.

An ulcer deformity in the presence of jaundice raises the question of whether the ulcer is responsible for biliary obstruction. Although peptic ulcer can do this, it happens very, very rarely and it is more probable that the ulcer is complicated by disease of the biliary system or that the deformity is the result of a tumor.

Bleeding may be the first indication of a duodenal ulcer. However, carcinoma must always be suspected when this occurs in the later years of life and in the absence of other symptoms of ulcer.

The important thing to remember is that carcinoma can completely simulate the radiographic appearance of duodenal ulcer. Therefore, this appearance in elderly persons without typical ulcer symptoms must always be viewed with suspicion and a careful investigation made for a possible carcinoma of the pancreas.

Summary

Most patients with peptic ulcer can be easily and reliably diagnosed by roentgen examination. However, there are numerous patients in whom the x-ray cannot be relied upon for a correct diagnosis. The number of these cases are fairly large because other conditions may give symptoms suggesting ulcer and because approximately 3 percent of ulcer patients fail to show a typical deformity at some time during their disease.

A correct diagnosis depends in large part upon an evaluation of the symptoms supplemented by a judicious use of laboratory data. The symptoms of an uncomplicated peptic ulcer follow a definite pattern. This pattern is described and how it may be influenced by other factors.

The differential diagnosis between gastritis and cases of peptic ulcer without radiographic deformity is discussed. The differential diagnosis between benign and malignant ulcers of the stomach and duodenum is also described.

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HOUSE OF DELEGATES REPORT

continued from page 531

ecutive Secretary confer with the War Food Administration and request that it publicize the action of the House of Delegates to every doctor in the State and to the public.

The Secretary presented the following resolution submitted to the House by the President:

WHEREAS the year 1944 marks the centennial of the founding of Butler Hospital in Providence, the first hospital of any kind in Rhode Island, and

WHEREAS the high standards set by its Trustees and its Administrators through the century of its life have fulfilled the vision and wisdom of its Founders in creating such a hospital, and the many contributions in research and in progressive scientific methods of treatment of nervous and mental disorders have made it one of the outstanding institutions in the country, and

WHEREAS the present superintendent, Dr. Arthur H. Ruggles, as has each of his predecessors, holds Fellowship in the Rhode Island Medical Society, and is recognized throughout the country as an outstanding leader in the fields of psychiatry and mental hygiene, and has been honored by his colleagues with the Presidency of the American Psychiatric Association, and of the Providence Medical Association, therefore be it

RESOLVED that the Rhode Island Medical Society, through its House of Delegates in Assembly this 28th day of September, 1944, extend to Butler Hospital, its Trustees, its Corporation, its Superintendent and its staff the felicitations of this Society for 100 years of outstanding service to our State and country, and best wishes for continued success and leadership in its second century of existence.

Dr. Harold G. Calder moved the adoption of the resolution. The motion was seconded and unanimously passed.

The Secretary presented the following resolution to the House of Delegates from Dr. Samuel Adelson of Newport:

WHEREAS the members of the Division of Medical Examiners within the Department of Justice of the State of Rhode Island are appointed to hold office at the pleasure of the Attorney General, and

WHEREAS such members of the Division of Medical Examiners are stipulated by law to be "able and discreet men learned in the science of medicine" and not necessarily trained pathologists, therefore be it

RESOLVED that the House of Delegates of the Rhode Island Medical Society approve of an amendment which would make it compulsory that all medico-legal autopsies within the State of Rhode Island shall be performed by a doctor of medicine with specialized training in pathology, and be it further

RESOLVED that the House of Delegates instruct the Committee on Public Laws of the Society to study the problem and to prepare suitable legislation to amend the General Laws regarding medical examiners and coroners to achieve this purpose.

Dr. Clarke discussed the resolution and expressed the belief that in the postwar period a full-time pathologist might well be employed by the State to conduct all medico-legal autopsies. The resolution was discussed at length and finally Dr. Abbate pointed out that the purpose was apparently to have eventually a full-time pathologist as State Medical Examiner and therefore he moved approval of the resolution. The motion was seconded and passed.

The Secretary read a communication from the State Dental Society inquiring as to the possibility of transferring dental books stored at the Rochambeau branch of the Providence Public Library to the Medical Library for temporary or permanent storage. The motion was made that the matter be referred to the Library Committee with power to act. The motion was seconded and passed.

At the invitation of the President the Executive Secretary discussed the medical-economic implications of the Rhode Island Cash Sickness Compensation Act in the light of its first year and a half of experience. He cited recent press comments and elaborated on the problems which appear to be inherent in the matter of medical certification for claimants of benefits.

There was free discussion by the members of the House regarding the Cash Sickness program, and the matter was concluded with the recommendation from the President that all the delegates give careful thought to the matter and that they be prepared to express concrete opinions regarding improvements of the Act at the January session of the House of Delegates.

The meeting adjourned at 10:55 P. M.

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ORAL PATHOLOGY

continued from page 523

on mouth infections writes: "There can be no excuse for a dentist, who finds infection in a patient's mouth, not to inaugurate or give advice for its removal. The dentist who sees persons who are presumably well has the opportunity to save more lives than the physician, who rarely sees a person until he is seriously ill." He also states: "There can no longer be any excuse why a physician should not study the mouth of every patient who comes to him for treatment, whatever the trouble may be. Infection in the mouth should be immediately removed and this without regard to what the mouth infection may or may not have to do with the condition or disease found." He goes on to say: "There can be no justification for tolerating infection longer than absolutely necessary. It is a fact that many persons acquire an immunity against the pathologic germs found in their mouths, and they may tolerate them for long periods, but no one knows when this immunity will cease. Consequently, the platform on which every physician and dentist must stand is: that no matter what is the cause of that disease, and no matter how negligible the part the infected teeth and gums play in the disease or disturbed condition, it is dangerous and a menace to allow him to be a carrier of infection. Any serious illness, or other infection, or any injury, or necessary operation (even pregnancy) may reduce the individual's ability to fight his mouth infection, and he becomes seriously, perhaps dangerously, ill on account of being a germ carrier. Although a large number of physicians are still very careless about noting the seriousness of mouth infection, the layman has now been educated to the point where he demands to know about his mouth and to have the menace of infection removed. However, although many brilliant cures are caused by surgical eradication of infected areas, one should be careful not to promise a cure of a distant condition, even when that condition may definitely have been caused by the mouth infection. The patient should always be told that the surgical removal of the infection in the mouth does not remove the germs which may be localized in the distant part of the body, nor does it immediately cure an inflammation caused by these germs in a distant part, nor restore degenerated tissue, but that it will remove the primary source of infection."

Often complications after extractions set in where bacteria enters lymphatics through the extracted wound and sometimes microorganisms enter under a flap as in third molar region. At the beginning there is an edema causing marked swelling of the subcutaneous tissue. Then later infection sets in. The swelling is more marked and develops into cellulitis, and may later develop into a phlegmon. Phlegmons are more serious than abscesses because they produce cellulitis which does not tend to localize and suppurate, but forms brawny inflamatory infiltration. The course of the diseases varies with the type of bacteria present.

Fractures of the jaw

In the section on fractures, Dr. Thoma has revised his material to bring the subject of fractures up to date. He has included many new photographs and colored plates showing all types and forms of fractures, especially those pertaining to the maxilla. The diagrams, x-rays and photographs of the maxillary fractures by Thoma are the last word in this field. The diagrams show every possible form of maxillary fractures including sinuses, orbits and nasal bone. This section is also well represented by x-rays. There is practically one or more x-rays on every type of fracture pertaining to each case.

Protein and drug allergy

Allergy is a state in which tissue becomes hypersensitive to substances which normally are harmless. Some people are sensitized to food serums or animal products, others show oral or skin eruption such as, urticaria, eczema, angioneurotic edema, purpura, erythema multiforme, acneform eruptions, herpes, and aphthae.

Neuralgia, covering symptomatic and idiopathic

Symptomatic type of neuralgia is of peripheral origin and has different symptoms such as: dry caries, pulpitis, periodontitis, malocclusion, temporomandibular irritation (Costen syndrome), retained teeth that are impacted and try to erupt, subperiosteal abscesses of the tongue, glossitis, maxillary sinusitis, fracture of jaw, wound pain (extraction pain, dry socket), carbuncle of skin, stomatitis, canker sores, herpes zoster, syphilitic lesions, ulcers, mumps, cancer. Idiopathic type of neuralgia is known as tic douloureux and its cause

continued on page 553

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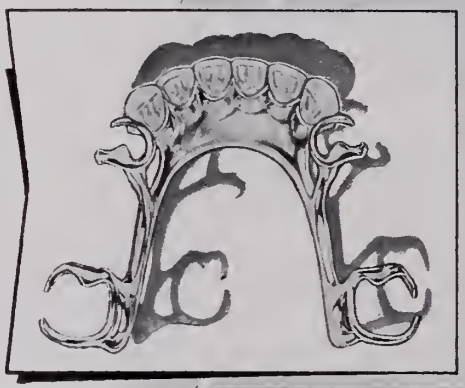
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ORAL PATHOLOGY

continued from page 551

cannot be determined. Pain is an important sensation that varies in each individual and interferes with patient's comfort and work. The subjective symptoms are the outstanding features of this disease, and patient has recurrent attacks of stabbing excruciating pain known as the trigger point. The treatment of symptomatic neuralgia is cured by removing the cause of the disease. In tic douloureux, alcohol injections of the nerves are successful, but these give relief only for a few months. Permanent relief is obtained by total or differential section of the sensory root posterior to the gasserian ganglion.

Conclusion

(1) "Oral Pathology" is an ideal reference book, and should be used in all dental schools.

(2) The earnest student of dentistry will find this textbook a vast storehouse of information, the careful study of which will have a broadening effect on his dental outlook.

(3) It is an outstanding book for the oral surgeon, or specialist, who is interested in the microscopic examination of pathological tissue.

(4) To the general practitioner, who has lost contact of his histopathology, and is too busy doing general dentistry, this book is of very little value; he can, however, still make some use of this book in the x-ray interpretations and the colored photographs of the different oral lesions which are well illustrated and have been on the increase in the past few years.

(5) Dr. Thoma has made this book an outstanding contribution to the dental world.

MEDICAL EDUCATION — OLD PURPOSES AND NEW METHODS

continued from page 514

side of the lecturer's desk. If the art of life, as Lawrence Lowell[5] puts it, "lies largely in distinguishing the eddy from the stream", was not that knowledge largely acquired in each of us by absorption, through our personal relations with the men of the preceding generation?

In establishing in 1944 a Department of Medical Sciences, Brown University is reviving, within her halls, a tradition of long and honorable standing. The opportunity is at hand as never before, to knit together the academic departments, particularly those devoted to teaching and research in science, together with her laboratories and libraries with her pre-medical students and the junior and senior members of the medical profession in Providence. The University doors are again open to student, interne, resident, practitioner and hospital personnel. May both parties gain profit from such a conjunction of spirits, each finding in the other a sense of time and place, fitting to the occasion.

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4. W. W. Keen, Brown University Magazine (April, 1896).
5. A. Lawrence Lowell, *Facts and Visions* (Cambridge, 1944).

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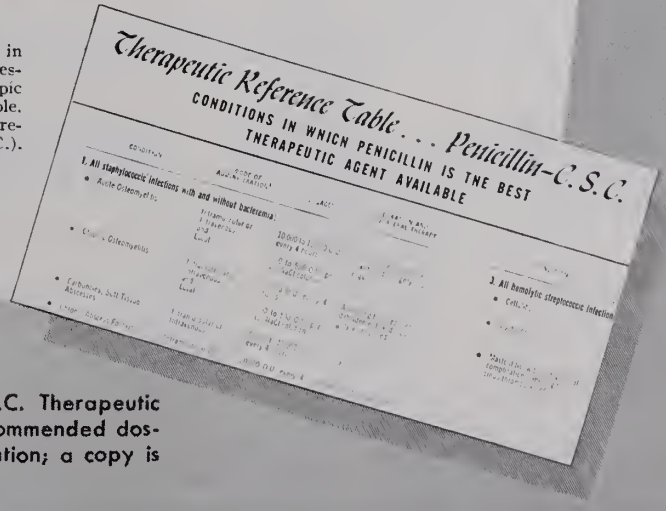
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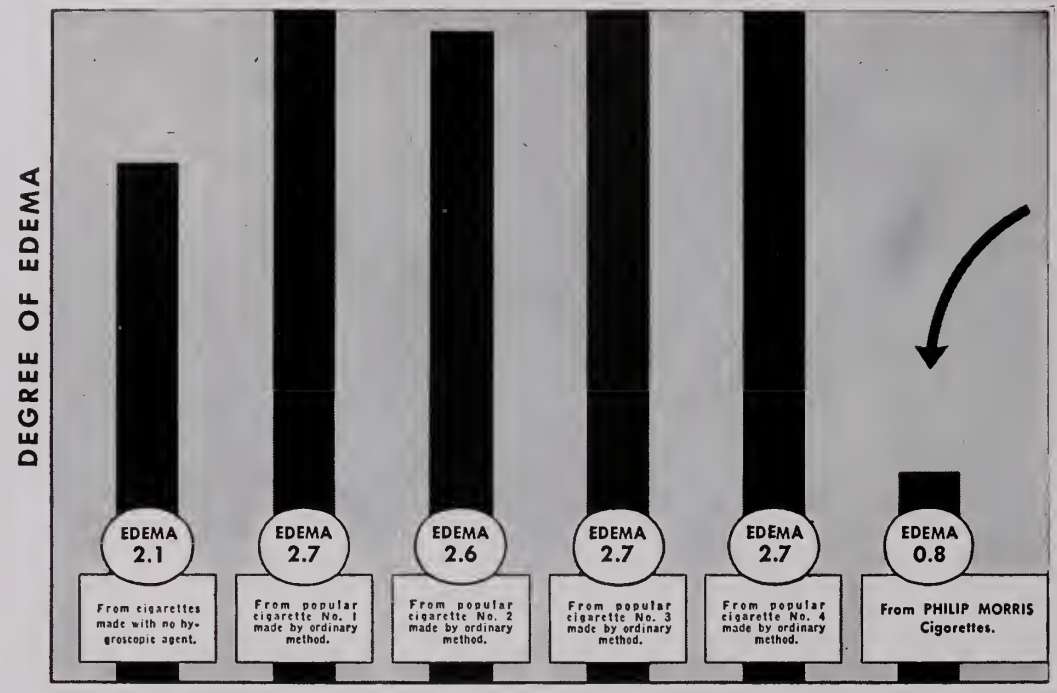
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The situation regarding heavy cream has become increasingly critical owing to a definite shortage of butterfat.

In the other New England States action has been taken to deny all requests for heavy cream for medical purposes until this critical war period is over.

Therefore, we wish to inform you of the action taken by the House of Delegates of the Rhode Island Medical Society on September 28, 1944, as follows:

> *"In the opinion of the Rhode Island Medical Society 19% cream fulfills all the necessities for cream in medical practice, and therefore all requests for cream of butterfat content in excess of this amount should be denied."*

In accordance with the above decision, the Medical Advisory Committee will no longer approve requests for heavy cream.

This information is sent to you in advance of public notice so that you may be prepared to instruct your patients accordingly.

Your cooperation in this matter will be appreciated.

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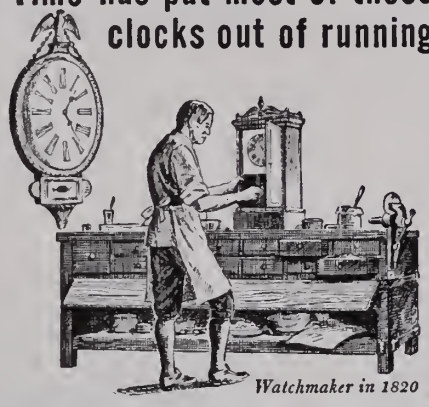
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[1] Diseases of the Skin: Sutton & Sutton, 1939, p. 99.

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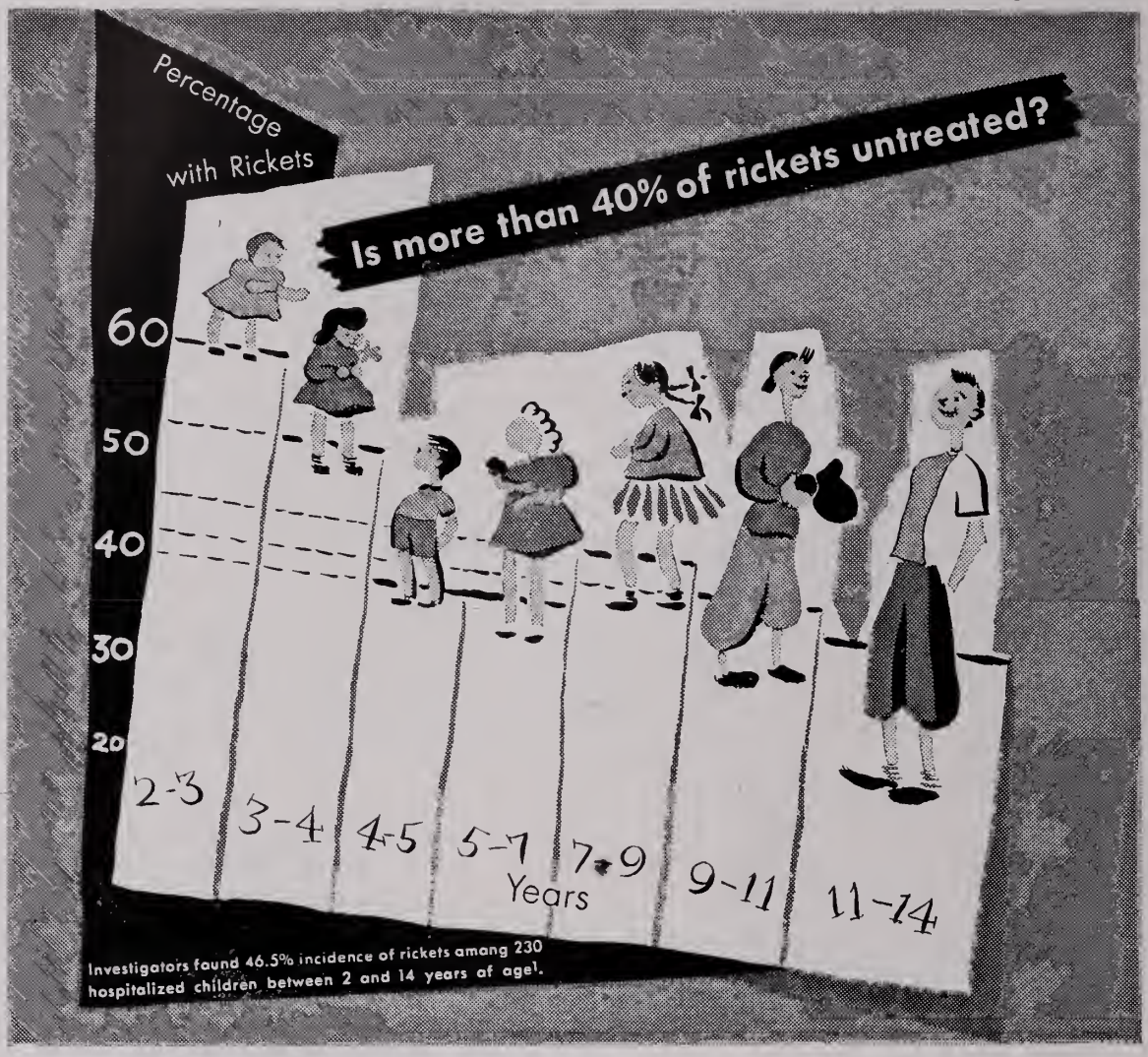
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1. Fallis, R. H.; Jackson, D.; Eliot, M. M., and Park, E. A.: Am. Jrl. Dis. Child. 66:1 (July) 1943. Note: A reprint of this paper is being mailed to all physicians. Additional copies are available upon request.

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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1. Fauley, G. B., Freeman, S., Ivy, A. C., Atkinson, A. J. and Wigodsky, H. S.: Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med., 67:563-578 (Mar.) 1941.
2. Cornell, A., Hollander, F. and Winkelstein, A.: The Efficacy of the Drip Method in the Reduction of Gastric Acidity Am. J. Digest. Dis., 9:332-338 (Oct.) 1942.
3. Winkelstein, A., Cornell, A. and Hollander, F.: Intragastric Drip Therapy for Peptic Ulcer; Summary of 10 Years' Experience, J.A.M.A., 120:743-745 (Nov. 7) 1942.
4. Upham, R., and Chaikin, N. W.: A Clinical Investigation of Aluminum Phosphate Gel, Rev. of Gastroenterol., 10:287-297 (Nov.-Dec.) 1943.
5. Lichstein, J., Simkins, S. and Bernstein, M.: Aluminum Phosphate Gel in the Treatment of Peptic Ulcer. Am. J. Digest. Dis. In Press.



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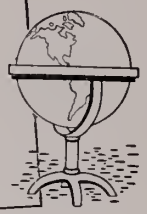
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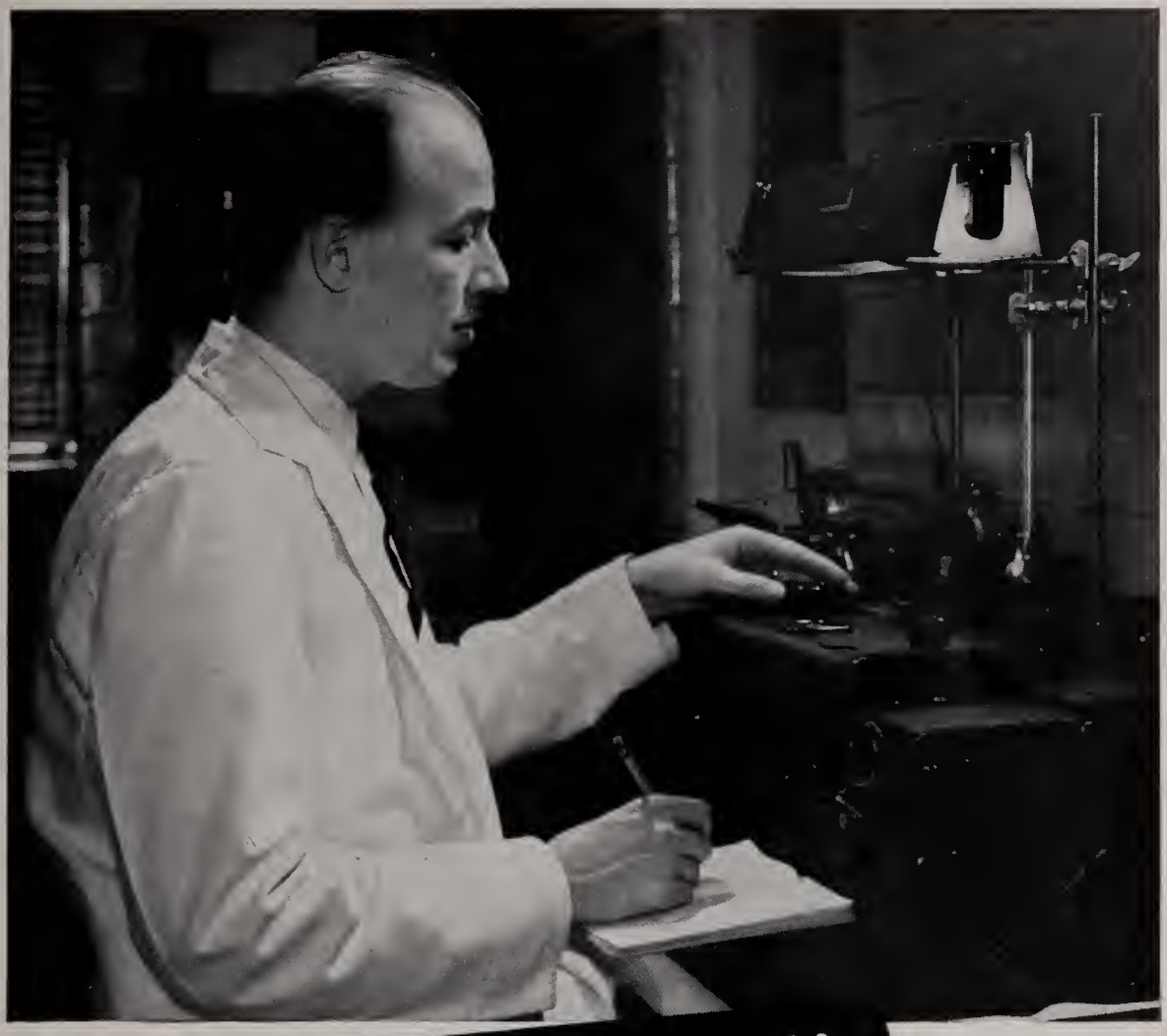
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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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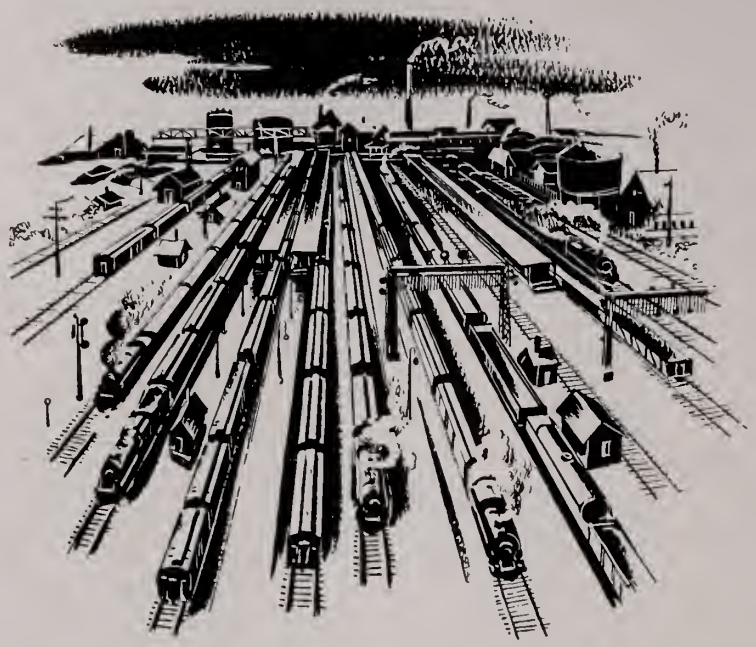
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVII NOVEMBER, 1944 No. 11

CARCINOMA OF THE ENDOMETRIUM

GEORGE W. WATERMAN, M.D., F.A.C.S.

The Author. *George W. Waterman, M.D., F.A.C.S.; Surgeon-in-chief, Department of Gynecology, Rhode Island Hospital.*

At the Tumor Clinic of the Rhode Island Hospital we have the records of 140 cases of Cancer of the Endometrium on file from 1924 to 1942 inclusive. The 140 records represent consecutive cases seen at the Clinics or in private practice, and include all cases treated or untreated or who received their primary treatment elsewhere and were later admitted to our service for treatment.

As many of these patients were private cases of Dr. Herman C. Pitts, our former Chief-of-Service, I wish to acknowledge his permission to include them, and to thank him for his continued interest and inspiration and for his help in the follow-up of these cases.

Eighty of this series of 140 were treated between 1924 and 1938, and have been followed for five or more years. It is with these 80 cases that this report is mostly concerned. In a special study of 48 hysterectomy specimens after radium treatment, to be presented as part of this report, many of the cases not requiring follow-up are taken from the list of those treated later than 1938.

The purpose of this study, which is the first to be undertaken by us on this subject, is to take account of stock; first to ascertain general factors, i. e. (1) marital state, (2) gravidity, (3) age incidence, (4) symptomatology, (5) associated pathology; second, to study the type of cases that were coming to our Clinic, whether early or late, and in what proportions; third, to determine the so-called grade malignancy as shown by microscopic structure and kind of cell predominating the picture; fourth, to find out what our five year survival rates are, how they compare with the rates published by others for similar series of cases, and to what extent stage of advancement of the growth and grade of malignancy of tissue plays a part in prognosis, to take up the problem of treatment, to see where our best results have occurred, whether with radium alone, surgery alone, or with a combination of radium followed by surgery; fifth, as a special problem, we have studied through the cooperation of Dr. B. Earl Clarke, Chief of the Pathology Department, 48 hysterectomy specimens to see how effective preliminary radium treatment has been in ridding the uterus of cancer cells, in order that we may from our own experience better decide to what extent we may be justified in depending upon radium alone to control the disease, or contrawise feel obliged to recommend surgical follow-up.

I. General Factors

1. Of the whole series of 140 cases (1924-1942) 124 were married, 16 were single, i. e., 88% had been potentially in a position to become pregnant.

2. The following chart shows the state of gravidity, number of children or pregnancies from none to ten, with underlying line showing number of cases in each group.

0	1	2	3	4	5	6	7	8	9	10
43	25	26	12	11	1	5	3	5	3	3

In this series therefore, as 88% were married women and as slightly over 33% had never been pregnant, and 67% had two or less pregnancies, it can be said that Cancer of the Endometrium is in the greater part the disease of the childless or relatively unfertile woman. It is noted however, that 19 patients — 13% had more than five children or pregnancies each.

3. The age incidence is shown for Cancer of the Endometrium and is compared in an opposite column with the age incidence found in a group of consecutive cases of Cancer of the Cervix from 1921-1942 inclusive. A third column gives relative proportion by age groups.

CANCER	ENDOMETRIUM	CERVIX	PROPORTION
Age group	1924-1942 140	1921-1942 770	1:6
Under 31	0	26	—
31-35	0	51	—
36-40	3	97	1:33
41-45	4	98	1:24
46-50	15	118	1:8
51-55	24	115	1:5
56-60	22	114	1:5+
61-65	29	55	1:2—
66-70	26	47	1:1.8
71-75	14	32	1:2.3
76-80	2	14	1:7
Over 80	1	5	1:5

continued on next page

It will be noted that while the sharp rise in incidence of Cancer of the Cervix comes between the years of 36-40, the corresponding rise in the incidence of Cancer of the Endometrium does not come until between the years of 51-55, i. e., about fifteen years later. On the other hand the incidence of Cancer of the Cervix dropped after the 60th year more than one half, while the corresponding drop in Cancer of the Endometrium did not occur until after the 70th year, i. e., 10 years later. It will be noted that while the average incidence of Cancer of the Endometrium to Cancer of the Cervix for the two groups as a whole was in the proportion of 1:6, that the relative frequency in the early age groups, up to 50 years was much lower, the proportion during the 6th decade about average, (1:5), and during the 7th decade and a half of the 8th (61-75) about 1:2.

4. Symptomatology. Bleeding from the vagina was by far the most frequent first noticed symptom. This bleeding occurred anywhere from two (2) days to fifteen (15) years before first examination. The greatest number gave the duration of symptoms as one year (21) the next as six months (19), the next as three months (10), the next as one month (6). Only three patients complained primarily of watery discharge.

5. Associated Pathology. The following pathological conditions were found associated with the Endometrial Carcinoma in the series: (1) Leiomyata 25; (2) Polyps-non cancerous 3; Polyps cancerous 4; Polyps fibroid 1; Papillary cystadenoma of the ovary 1; Parametrial carcinomatous cyst 1; Endometriosis of the uterine wall 4; Parovarian cyst with torsion of pedicle 1; Dermoid cyst of ovary 1; Procidentia of the uterus 1; Papilloma of urethra 1; Bicornuate uterus with carcinoma in one horn 1; Primary carcinoma of lung with metastasis to spine 1; Carcinoma of breast 2; Adenoma of thyroid 1.

The incidence of leiomyomata in this series — 18% seems quite low as compared with the incidence of fibroid tumors reported by other clinics. Healy reports 38% at the Memorial Hospital in New York, Masson reports 36% at the Mayo Clinic and George V. Smith 30.6%. Daniel G. Morton, however, reports 18.1% in a series of 104 cases reported in 1939. This difference may perhaps be explained by a lower incidence of surgical removal in our series. It is possible that small fibroids might escape detection where hysterectomy was not done.

II. Classification

Classification of cases into Clinical Stages, according to degree of advancement of the growth. Some system of classification as to size of growth at first examination or treatment seems necessary and convenient in attempting to estimate the efficacy of treatment. While admitting the difficulties of accurately determining the extent of growth by available means such as bimanual examinations, uterine sounding etc., we still believe that we can accept certain criteria as indicating the limits of spread of the disease, and so group our cases into Stages with not too great a margin of error. We have therefore used the criteria for grouping as outlined by Healy and used by Ward and others; Stage or Group I, the uterus is of normal size, canal 3 inches deep, freely moveable and no evidence of local or distant metastasis; Stage II, the uterus the size of a 2½ months pregnancy, canal 4-4½ inches deep, still no fixation and no obvious metastasis; Stage III, the uterus the size of a 3½ months pregnancy with some break through into parametrium or adhesion to intestine or omentum, but still mobile, still technically operable; Stage IV, the large fixed uterus, inoperable, with frozen pelvis or metastasis to local lymphatic drainage area or to vaginal walls.

In this series of 80 cases to be reported on the basis of 5 year survivals, there were 19 Stage I, 23.5%; 34 Stage II, 42½%; 15 Stage III, 18.5%; and 12 Stage IV, 15% cases. Thus about two thirds of the cases were judged to be early or favorable for operation, a much better outlook than that found in Cancer of the Cervix where the early or favorable group amounts to less than one third. Therefore, Cancer of the Endometrium should be a very favorable type of Cancer to treat.

III. Pathological Grading

Another factor which is considered of prognostic significance by some well recognized authorities in Cancer of the Endometrium is the so-called Pathological Grade. Here the grouping or grading is done according to the microscopic appearance and arrangement of the cancer cells, the more adult or highly differentiated cell tumors comprising the lower grades, and the less differentiated and highly anaplastic types the higher grades of malignancy. Dr. B. Earl Clarke, our Pathologist distinguishes three grades: Grade I includes those tumors whose cells are of (1) the highly differentiated type of papillary adenocarcinoma, or (2), of the type described and called adenoma malignium by Ewing. Grade II includes a less differentiated group with gland formation still evident but with some solid blocks of cells with many mitotic figures. Grade III carcinoma is characterized by cells which are totally anaplastic, sheets of cells with no tendency to gland formation. We have 67 tumors graded in this way by Dr. Clarke for study.

IV. Results — Five Year Survival Rates
As influenced by Stage, Grade and Treatment

The five year survival rate for the whole group is 29 out of 80 or 36%. As this is the uncorrected

figure with no deductions and including all cases seen, whether treated or untreated because too advanced, or treated primarily elsewhere and referred to us later for treatment of recurrence or metastases, we speak of it as the absolute rate in distinction from the relative rate which includes only cases treated primarily by us. The following chart shows the survivals by clinical stages.

80 Cases	1924-1938	29	5 Year Survivals	36%		
Stage I	19 cases	12	5 Year Survivals	63%		
Stage II	34 cases	13	5 Year Survivals	38%		
Stage III	15 cases	4	5 Year Survivals	26%		
Stage IV	12 cases	0	5 Year Survivals	0%		

53 | 25 | 47%

The direct relation between Clinical Stage and Survival rate is here evident.

In comparison with results in treatment of Cancer of the Endometrium at other clinics in this country, our absolute figure of 36%, with 47% salvage in favorable cases is not particularly good. For instance, George V. Smith reports for the Brookline Free Hospital that of 307 cases treated by surgery alone before 1931, a salvage of 55%. Ward and Sackett report a series of 142 cases with absolute 5 year salvage of 44.4%. Heyman of Radium-hemmet in Stockholm reports of 416 patients absolute salvage of 35%. Morton in a review of the literature in 1936 found 5 year salvage figures ranging from 29.4% to 60%. Fricke reports 39% salvage of 109 cases treated by Radium alone at the Mayo Clinic.

A study of the treatment employed in our cases points to the cause of our difficulty. We find that of 19 Stage I, early favorable cases, 14 had Radium only, and that although 9 survived 5 years or more, i. e., 64%, that 4 required further treatment, 2 for local metastasis after 6 and 7 years, and that 2 required hysterectomy for recurrence in the uterus 9 and 11 years after their primary treatment. Four (4) cases had Radium followed by hysterectomy, of whom 3 survived 5 years or more. One had panhysterectomy alone and died 24 hours after operation of cerebral accident. Although the 5 year salvage (Radium alone) in this early group seems reasonably good, recurrences subsequently tend to spoil the record. And in view of the excellent results in early cases in other clinics where surgical removal played the leading role, 73.1% salvage in operable cases surgically treated by Masson and Gregg, 61.9% by Ward and Sackett, and 70.5% by Norman Miller, we must greatly question the advisability of not removing the uterus after Radium treatment in these cases. In our Stage II cases, the disadvantage of using Radium and X-ray alone becomes more pronounced. Of 9 cases receiving Radiation alone, only one survived 5 years. On the other hand, of 8 having hysterectomy alone, 5 survived 5 years. And of 10 cases receiving Radium plus hysterectomy, 6 survived, 60%. In a small group where supracervical hysterectomy followed by Radium was used, only 1 out of 7 survived 5 years, and she died of cancer in her 6th year. In Stage III, of 15 cases, 7 had Radium and or X-ray only. All died before the 5 year interval. One who had hysterectomy alone died after 4 years. Of 6 cases having Radium followed by panhysterectomy, 3 lived five years or more, 50%. One patient who had panhysterectomy elsewhere and was treated post-operatively with Radium and X-ray at our Clinic, died of cancer in her 6th year. At no time was she thought to be free of cancer. In Stage IV, of 12 cases there was no survival. All received some sort of palliative treatment. If we summarize our results according to the type of treatment given, we find that of the 80 cases,

43 patients were treated surgically with 19 survivors 44%
37 patients were treated with Radium or X-ray only 10 survivors 27%

Of the 43 patients treated surgically,

12 patients had surgery (panhysterectomy only) 5 survivors 41⅔%
9 patients had supracervical hysterectomy and Radium 2 survivors 22%
22 patients were treated with Radium and panhysterectomy 12 survivors 55%

that there were 30 cases Stage I, II and III, i. e., those technically operable, we find that 30 cases were treated by surgery, panhysterectomy or by Radium plus panhysterectomy, and of these 30 operable cases, 17 survived, 53⅔%. We also find that there were 30 cases Stage I, II and III, i. e., technically operable, supposedly comparable to the above group, which were treated by Radium alone. Of these 30 cases, 10 survived 5 years, 33⅓%. Here are figures, which, small in number perhaps, show quite clearly the advantage of using surgery as the key or principal part of the treatment, although the results with radium plus panhysterectomy are distinctly better than with surgery alone.

If surgery, panhysterectomy, is to become the important part of the treatment, there are certain essential surgical principles to be fulfilled. Obviously complete hysterectomy is required. To leave a potentially invaded cervix will be disastrous to good results, for while Radium may be used, or deep X-ray, later, the results in our series have been very discouraging. While it is probably not necessary to do the radical Wertheim operation, one should be careful to keep away from the uterine body and cervix, and not to break through the capsule of the uterus, as cancer cells often invade the myometrium deeply, even in the small uterus. Secondly, the high incidence of fibroids found when Cancer of the Endometrium is present, up to 38% in some series, makes it advisable to do the complete operation in all cases of fibroids occurring in the age group of 45 or over. Thirdly, as carcinoma cells invade deeply, and are not infrequently found in the oviducts, or may be squeezed out during operation,

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HEMOLYTIC DISEASE OF THE NEW BORN (*Erythroblastosis Foetalis*) IN ONE OF TWINS*

MAURICE ADELMAN, M.D.

The Author. *Maurice Adelman, M.D., Visiting Physician, Department of Pediatrics, and Assistant Pathologist, Lying-In Hospital, Providence.*

It is now fairly well established that erythroblastosis foetalis, or as Kariher has suggested, hemolytic disease of the new born, is caused by iso-immunization of the mother by a dominant hereditary blood factor in the fetus, usually the Rh factor. It has long been recognized that icterus gravis, fetal hydrops, hemolytic anemia of the new born etc. were either variations in degree of the same underlying condition, or were very closely related, and it is therefore, more nearly correct to use the new designation. "Erythroblastosis feotalis" was first used because of the work of Levine and Stetson in 1937 in studying the serological properties of the blood of a group O mother who was delivered of a macerated fetus, and the work of Landsteiner and Wiener in 1940 who noted that rabbits injected with red cells of the rhesus monkey developed an anti-body (called the Rh factor) which could be used in testing human blood. By means of this new immune serum all human bloods could be divided into two groups. It is now known that 85% of all human blood of the white race contains this factor and this type of blood is designated Rh +. The remaining 15% does not contain this factor and is called Rh —. This Rh factor is present in the red cells only, and differs from the A and B factors which are present not only in the red cells but also in the tissue cells, blood serum and other body fluids. The anti Rh agglutinin is an acquired anti-body as opposed to the anti A and anti B agglutinins which are always and normally present in the organism.

Following this discovery, the theory of iso-immunization as cause of habitual miscarriages, hemolytic disease of the new born, intra group transfusion reactions etc. was brought forward by Levine and other workers. Hemolytic disease of the new born serves as the first known example of selective fetal or neo-natal morbidity due to a genetic and constitutional difference in a normal blood property. In spite of the widespread interest in these conditions, and the number of articles that have appeared in the literature, so far as I know, less than 6 cases occuring in twins have been studied, and Kariher's case and those of Buhler, Seely and McCormick, Javert, Snyder and Ford are the only ones published. It is estimated that non-identical twins with hemolytic disease of the new born would occur about 1—18,000 deliveries. Wiener and Landsteiner first suggested that the mating of an heterozygous Rh + male with an RH — female would produce 50% normal offspring and 50% affected siblings. The following case bears this out and will add another small bit of evidence to the rapidly mounting total of statistics both as to the causation of this condition as well as to its hereditary transmission.

Case History

Mrs. H. G. C. age 35. She has 1 brother and 2 sisters alive and well. They all have 1 or more children and have no history of abnormal premature births, miscarriages etc. Two years before the birth of the present set of twins she was delivered by Caesarean section of a normal male infant. She has never been transfused and has had no miscarriages. On December 16, 1936 she was again delivered by Caesarean section. This time she gave birth to a set of twins; one male and one female. It was noted at the time of operation that there were two placentae which appeared to be normal and that the infants looked equally well, although the male weighted 7 pounds and 4 ounces, while the female weighed 6 pounds and 9 ounces. The mother and the male infant did well and they were both discharged in good condition on the twelfth day post-partum.

The female infant was noted to be drowsy and slightly jaundiced on the second day. The jaundice rapidly took on a greenish tint, and when the infant was examined at 48 hours of age it was found that the liver and spleen were moderately enlarged, and that drowsiness was quite deep. It was very difficult to get the baby to swallow. Blood examination at this time showed Hgbn. 53%-sahli, red cells 1,350,000 and white cells 19,800. There was noted a severe macrocytic anemia and 200 nucleated red cells were counted for every 100 white cells. The blood picture remained essentially the same during

*Presented at the 133rd Annual Meeting of the Rhode Island Medical Society, at Providence, May 25, 1944.

the next week, in spite of the fact that the baby received 550 c.c. of citrated blood intravenously in doses of 50-75 c.c. once or twice daily. X-ray examination of all of the long bones on the third day of life showed "none of the characteristics of erythroblastic anemia at this time". By giving daily transfusions it was just barely possible to keep the baby's blood at about the level found at the first examination. Clinically, however, the child's condition seemed to be growing steadily worse. On the thirteenth day the spleen was removed in an attempt to halt the hemolysis. This was accomplished without difficulty by Dr. R. W. and the convalescence was uninterrupted, and no further transfusions were given. The jaundice began to decrease in intensity and the patient was discharged on the 34th day of life in excellent condition. Since that time she has developed and progressed normally and is now about the same size as her brother. The excised spleen weighed 30 gms. and was 6½ by 3½ by 2 cms. The microscopic diagnosis was "myeloid hyperplasia and increased hemocytolysis or erythroblastic anemia".

Review of Case

In reviewing this case it is obvious that the transfusions were doing no good. The father was used as a donor twice. Due to the number of years since this case was studied, it has been impossible to trace the other donors and determine their Rh reactions but it would be safe to venture that certainly not more than one of them was an Rh — type. In spite of this the baby did not have any transfusion reactions, although the hemolysis continued unabated and at about the same rate during the entire ten days of pre-operative treatment. The probable explanation of the recovery is that the anti Rh substance in the baby's blood had been exhausted at about the time of the splenectomy and recovery might have followed without the operation and with no more transfusions.

The data on the family's bloods are as follows:-

Father — Mr. H. G. C.	O	+
Mother — Mrs. H. G. C.	AB	—
First son	B	+
Twin son	A	—
Twin daughter	A	+

Father's blood has been tested at Boston Blood Grouping laboratory and has been shown to be heterozygous.

It is of interest to report that although 7½ years have now elapsed, the mother's blood still contains an appreciable amount of the anti Rh substance.

It has recently been possible to check the reactions of 2 of the mother's brothers—one brother (maternal uncle of patient) is type B Rh — and the other is type B Rh +.

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CARCINOMA OF THE ENDOMETRIUM

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the greatest care should be taken to clamp or tie off the tubes at their fimbriated ends and also close to the uterine horns. A long curved clamp applied just outside the lateral uterine border accomplishes the latter purpose and serves as a tractor as well. Fourth, greatest gentleness in handling the uterus, to avoid squeezing and so forcing cancer cells out into the lymphthatics of the broad ligaments is necessary. Fifth, if for any reason supracervical hysterectomy in any uterine enlargement is contemplated, a careful curettage should certainly be performed in any woman over 45 years of age, to rule out carcinoma. If carcinoma is found, and the patient's condition or the operator's skill limits the possibility of panhysterectomy, Radium and X-ray should be used in full dosage, rather than incomplete surgery. The condition may thus be rendered operable at a later date, while the patient's health may be improved to stand surgery. Too often patients are referred to our clinic after supracervical hysterectomy, when Radium and X-ray, although helpful, are at a disadvantage, difficult to apply properly, and almost sure to be followed by questionable or poor results.

Having discussed results as affected by stage and treatment, let us now return to consider the effect of pathological grade on prognosis.

Effect of Grade of Malignancy on 5 Year Survival Rate

67 Cases graded by B. Earl Clarke 1924-1938

			Year Survivals 1	2	3	4	5		
Grade I									
Stage I	10	19	9	9	8	8	7	70%	63%
Stage II	9		9	8	7	7	5	55%	
Stage III	3	5	2	2	2	2	2	66%	
Stage IV	2		1	0	0	0	0	0	
	24		21	19	17	17	14	58½%	
Grade II									
Stage I	7	21	7	7	6	6	6	85%	57%
Stage II	14		13	10	10	6	6	46%	
Stage III	4	7	4	2	2	1	1	25%	
Stage IV	3		1	0	0	0	0	0	
	28		25	19	18	13	13	46%	
Grade III									
Stage I	2	6	1	0	0	0	0	0	33⅓%
Stage II	4		3	3	2	2	2	50%	
Stage III	6	9	4	1	1	1	1	12½%	
Stage IV	3		1	0	0	0	0	0	
	15		9	4	3	3	3	20%	

The accompanying chart shows that there were 24 cases Grade I with 14 survivals, 58½%; 28 Grade II with 13 survivors, 46% and 15 Grade III with 3 survivors, 20%. These figures seem to agree fairly closely with those of Healy and Brown, who in a larger series had 95 Grade I with 60% survivors—5 years; 45 Grade II with 42% survivors and 39 Grade III and IV with 20% survivors. Fricke also in a study of cases treated with Radium alone found that the prognosis was directly in relation to the

continued on next page

CARCINOMA OF THE ENDOMETRIUM

continued from preceding page

grade of malignancy, the better differentiated Grade I having a salvage of 79%. The Grade II of 33%, Grade III of 25% and Grade IV of 12%. Our own and the reported cases in literature therefore seem to show that in Cancer of the Endometrium, grading is of prognostic value.

In order to determine whether the better outlook for Grade I cases might be due to the predominance of more favorable stage groups, the Grade groups were divided:

In Grade I the proportion of
Stage I and II : Stage III and IV was 4 :1

In Grade II the proportion of
Stage I and II : Stage III and IV was 3 :1

In Grade III the proportion of
Stage I and II : Stage III and IV was 2 :3

The highest proportion of favorable cases clinically in this series fall in the more differentiated types of growth, i. e., Grade I and II. The relation in the Grade III or anaplastic type is reversed, i. e., 2 :3. It may well be that the better prognosis in Grades I and II is more dependent on the earlier stage found than on the grade of malignancy itself, the more differentiated and slowly growing grades being brought to treatment at an earlier stage, while the anaplastic types, more rapidly growing, attain an advanced stage before being discovered and brought to treatment.

V. Study of Post-Radiation Hysterectomy Specimens

A study of especial interest because it should show the immediate effect which Radium possesses of ridding the uterus of tumor cells and consequently should offer us an estimation of its value in treatment when used alone, was suggested by the work of Donovan and Shields Warren. In a series of 48 uteri treated for Cancer of the Endometrium, first with Radium and then by hysterectomy, they found, on examination by the usual routine laboratory methods, only 5 specimens free of cancer cells. In some specimens they thought that the normal tissues had suffered more than the cancer tissue. Sackett reports that in a series from the Woman's Hospital that one out of three showed Cancer present. Healy and Brown found only 40% cancer-free, in a series receiving the maximum dosage of Radium and X-ray. Corscaden found 8 of 21 cases Cancer-free and George V. Smith 4 of 24 cases.

The records of 48 specimens of uteri removed after preliminary radium treatment were found in our laboratory. All had been removed 6 to 8 weeks or more after Radium treatment. All had been examined and described by Dr. B. Earl Clarke and his associates. Sections had been taken in routine manner from areas where cancer was thought most likely to be present. Serial sections were not done. Thirteen specimens were found to be Cancer-free, 27%. When classified as to Stage:

8 of 14 Stage I or 57% were Cancer-free.
4 of 24 Stage II or 16⅔% were Cancer-free.
1 of 9 Stage III or 11% were Cancer-free.

When classified as to Grade:

6 of 16 of Grade I or 37½% were Cancer-free.
6 of 18 of Grade II or 33⅓% were Cancer-free.
1 of 14 of Grade III or 7% was Cancer-free.

Of the 16 Grade I specimens:

7 of Stage I with 4 or 57% Cancer-free.
8 of Stage II with 2 or 25% Cancer-free.
1 of Stage III with 0 or 0% Cancer-free.

Of the 18 Grade II specimens:

5 of Stage I with 3 or 60% Cancer-free.
9 of Stage II with 2 or 22% Cancer-free.
4 of Stage III with 1 or 25% Cancer-free.

Of the 14 Grade III specimens:

2 of Stage I with 1 or 50% Cancer-free.
7 of Stage II with 0 or 0% Cancer-free.
4 of Stage III with 0 or 0% Cancer-free.
1 of Stage IV with 0 or 0% Cancer-free.

From the above table it is fairly obvious that the best effects of Radium are found in the Stage I where all Grades show 50% or better Cancer-free. In Stage II, Grades I and II show 25% and 22% Cancer-free — Grade III no results, 0%. In this small series Grade III offered the worst prognosis, even where similar Stages were considered. Perhaps in a larger series this might have been different, as it is generally believed that the less differentiated anaplastic grade is more susceptible to radiation. On the basis of this study where only 57% of specimens were Cancer-free after radiation in the most favorable stage, and only 27% Cancer-free in all cases, it seems fair to conclude that hysterectomy should still be considered essential in dealing with Cancer of the Endometrium.

Summary and Conclusions

1. 140 cases of Cancer of the Endometrium are presented for consideration as to marital state, gravidity, age incidence, symptomatology and associated pathology.

2. Absolute 5 year survival rates are given for 80 cases treated 1924-1938.

3. Classification of these 80 cases into Stage and Grade groups is given with basis for the same.

4. The effect of Stage and Grade on prognosis is shown.

5. 48 specimens of uteri removed after radiation are discussed as to the value of Radium in rendering the uterus cancer-free.

The effect of Stage and Grade on the cancer-lethal property of Radium in these 48 specimens is shown.

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NOW IT'S THE BLUE TRIANGLE

UNDER the official designation of the "Blue Triangle" plan a new program for financing of medical and dental bills has been introduced during the past month in Massachusetts by the Bankers Association of that state. Developed on the basis of a three year study by the Consumer Credit Commission of the banking group, and sponsored with the cooperation of fourteen clearing house associations throughout the state, the plan has received the endorsement of both the Massachusetts Medical and Dental societies.

The authors of the plan claim it has been made as simple as possible. Anyone desiring to pay the doctor's bill by installments can make application for a Blue Triangle loan through any participating doctor. A participating physician or dentist is one who agrees to endorse the patient's note form with full recourse, whereby he receives his money directly from the bank, subject to a 10% reserve to be paid him when the full amount of the loan has been paid if no other obligation of the borrower is in default.

The patient files his application with the bank for a loan, which, if approved, paves the way for him to secure the needed medical or dental care from the doctor willing to endorse the Blue Triangle note form for him. Repayments on the loan are made by the patient directly to the sponsoring bank in from six to twelve monthly payments, with a reasonable charge added for the banking service.

The sponsors of the plan point out that the Blue Triangle is "another answer to socialized medicine." "Every doctor", says the announcement, "will see quickly the merits of this bank-financing plan in helping to preserve a free, independent medical profession. Most people fail to take advantage of the pre-payment medical plans available. With the Blue Triangle plan designed for payment of medical expense not before but after it is created, doctors are in a position to arrange for the complete health needs of people in their communities." After reading that statement is it any wonder that we in Rhode Island ask just how the Massachusetts Medical Society can sponsor at its own expense its Blue Shield pre-payment insurance program for medical care as the solution of the problem, and at the next moment support a banking plan which is publicly proclaimed as a better solution since people fail to purchase pre-payment contracts.

As for answering the challenge of socialized medicine, so-called, we fail to see the point. In the first instance the sponsoring banks intend to make certain that the individual seeking the loan is a

continued on next page

good financial risk, and we question whether every citizen applying to the bank would merit a loan, any more than every patient would merit an endorsement of the loan by his physician. In addition, the patient will have to pay more for his medical care than formerly, for he must assume the carrying charges on the loan. Hence, the only direct benefit that we can see from this distance is the provision of installment payments for the patient, and the elimination of some bookkeeping for the doctor.

But what doctor wouldn't accept payments on an installment basis direct from the patient? Granted he might lose out on many claims unless he turned them over to a professional collection agency, but would he not take that risk as readily as he would that of endorsing a note for a sizable amount which he would have to return if the borrower was in default in his payments to the sponsoring bank? And what happens to the patient when the bank approves the application, but the doctor withholds his endorsement for personal reasons?

If we are in error in our conclusions we will welcome correction. We admit that our knowledge of the new plan is gleaned entirely from the releases issued in its promotion. But we do maintain that the plan is a successful banking procedure, and that it should be promoted as a loan and collection service, not as a panacea for the distribution of the costs of medical and dental care, nor as a bulwark to preserve the freedom of the medical profession. We still think that the pre-payment plan, as demonstrated so effectively by the Blue Cross, warrants support when approaching solutions to the distribution of health care costs.

EARLY MEDICAL HISTORY

While the official start of the Rhode Island Medical Society was made in 1812 when forty-nine doctors from all sections of the state, but mostly from Newport and Providence, signed the original act of incorporation, there has often been speculation as to what attempts had been made previous to that year to effect an organization. Society documents clearly record the first meeting in the Senate Chambers of the Court House in Providence, when, at ten o'clock on the morning of April 22, 1812, the founders met to organize in accordance with the act of incorporation passed by the Assembly that year.

We are privileged to reprint below, through the kindness of the Rhode Island Historical Society, a letter in their possession which gives evidence that an attempt was made at least once previous to 1812 to form a medical society. The letter, dated in 1795, was from a Dr. Benjamin Weight and addressed to Dr. Peter Turner of East Greenwich. The letter in its entirety is as follows:

Sir.

At a meeting of a number of
Physicians of the County of Washington
at the house of Robert Potter Esq. of South
kingstown January 5th AD 1795 It was
voted that you should be invited to attend a
meeting of said Physicians at the house of
Dr. Azel Anesworth of Hopkinton in said
County on the first monday of march next if
fair weather if not the next fair monday following to consult and agree upon proper measures and rules for forming a medical society
if you think such a measure to be of Public
utility and the advancement of medical knowledge therefore agreeable to said vote and in
behalf of said meeting with much respect
I wish your attendance at sd meeting at sd
time and place. Sir: I am with respect and
sentiments of esteem your friend and well
wisher

Benja Weight

South kingstown January 17th. AD. 1795
To Dr Peter Turner]

Little, if any, historical data is available on Dr. Benjamin Weight. In a *HISTORY OF THE MEDICAL PROFESSION in RHODE ISLAND,* prepared by a committee of Drs. Usher Parsons, Isaac Ray and George L. Collins, and published in 1877, several physicians of various degrees of eminence residing in South Kingstown are listed, among whom is a BENJAMIN WAITE. Undoubtedly this doctor is the same one who dispatched the letter reprinted above, in spite of the variance in the spelling of his name.

Dr. Peter Turner, to whom the letter is addressed, was born in 1751, and he served as surgeon of Colonel Greene's Rhode Island regiment. At the close of the War he settled in East Greenwich and was the first physician of any note in that section. He had many students, some of whom became outstanding physicians in the state. Dr. William Turner, who won an enviable reputation at Newport as a general practitioner and an operative surgeon, was his nephew.

The identity of the Dr. Azel Anesworth of Hopkinton and of Robert Potter, Esq., of South Kingstown, to whom reference is made in the letter, constitutes a matter for historical research. At the present writing none of the Society documents reveal any Dr. Anesworth, but as not more than nine of the original incorporators of the Society had their MD it is highly probable that Azel Anesworth had rightful claim to the title of doctor.

WE ARE STILL IN THE WAR

The American mania for speed expresses itself in many ways. For example, our armies in Europe have apparently their hardest battles ahead of them, and yet we find the arm-chair strategists at home naming the day for the war's end, and we have local arrangements completed for the celebration of V-day. We would like to think the battles on the Continent will be over in the immediate future. We would like to believe that the battles yet to be fought will not be the bloody ones anticipated. But we know in our hearts otherwise. And even if the Nazis collapse, we are ever mindful of the tremendous campaign being waged in the Pacific and in the China-Burma-India theaters where so many of our own colleagues are stationed. With the realization that Germany is still far from defeated, and that it will cost almost as much to fight Japan alone as it did up to now to fight both Germany and Japan, we express the sincere hope that everyone will travel at full speed in the next few weeks to oversubscribe the 6th War Loan.

THE TITLE OF DOCTOR

Since the General Assembly of Rhode Island has never provided against the assumption of the title of "doctor" by any person, whatever his business or profession may be, we have witnessed some interesting misuses of the title through the years. The extent to which the public can be misled, having placed implicit faith in the title of "Doctor", was never better illustrated than in the recent case brought to trial in Providence.

In this instance a man released from jail in a Massachusetts city on September 22 came to Providence the same day and took residence at a local rooming house. He secured employment at a local machine shop, and at the same time apparently circulated by word of mouth the information that he was a "Doctor". His success, and the public's gullibility, is best answered by the statement that when the law caught up with him nine prescriptions he had issued to patients were reported. Only the alertness of a Providence pharmacist in notifying the State Health Department when the imposter sought prescription blanks from him brought the culprit to court within ten days after his activities had started.

Never licensed in any phase of the healing art anywhere, and with no affiliations in Providence, this "Doctor" distributed his prescriptions on the basis of "experience" gained while working in the infirmary while serving a prison sentence at Leavenworth. And the amazing part of the story is that he acquired patients here who accepted him and his advice without question!

The Governor's commission appointed two years ago to study and revise the public health laws of the State may well consider the significance of the title of doctor and make adequate provisions to safeguard the public against its misuse. There are six professional groups authorized under the healing art statutes to use the title of doctor, and of the six the clarification for chiropodists is clearest for it stipulates that "No person granted a certificate under this chapter (278) shall display or use the title 'doctor' or its synonym without the designation 'chiropodist' or 'podiatrist', and shall not mislead the public as to the limited professional qualifications to treat human ailments." This same regulation should be adapted in similar manner for doctors of medicine, doctors of dentistry, osteopathic physicians, chiropractic physicians, and optometrists.

THE HORACE WELLS CELEBRATION

It is singularly fitting that the dental profession of this State join with contemporary organizations throughout the world on next December 11 to pay tribute to the memory of Horace Wells. One hundred years ago that date, as a young Hartford dentist, Wells made his great discovery of the pain-killing effects resulting from the inhalation of nitrous oxide. Since that time his memory has been enshrined throughout the world with memorial statues in Hartford and in Paris, France. This year, the centenary of his discovery, the dental profession of America is bringing more fully and clearly to the attention of the public in general the significance of Wells' contribution in the fields of dental and medical science. He was the real discoverer, the man who saw, demonstrated, and proclaimed. He furnished the spark that lighted the way to many new discoveries and inventions based upon his original genius. Rightfully then, should all tribute be shown his memory on this occasion, for his gift was not one to science alone, but to the alleviation of suffering of all peoples of the earth.

CORRECTIONS

In the listing of the membership roster of the Society in the October issue the name of Dr. Raymond G. Bugbee of Providence was inadvertently omitted from the Providence Medical Association listing.

In the listing of Pawtucket Medical Society Dr. Edward H. McCaughey should have been checked as serving with the armed forces.

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Arch. Otolaryng., 39:109-123, 1944.

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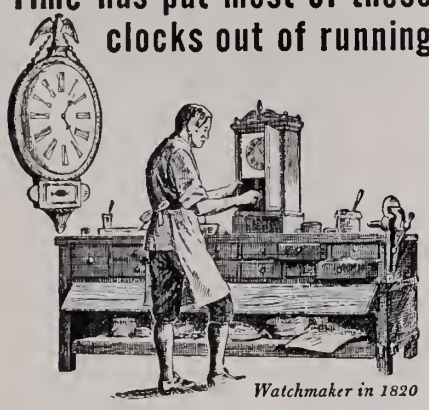
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THE CASE AGAINST THE IMPACTED TOOTH

HUBERT A. MCGUIRL, D.D.S. *of Providence, Rhode Island*

WHILE there is one school which feels that the impacted tooth should be "left alone" in as much as there is an absence of either subjective or objective symptoms or both, it is generally conceded that the conditions should be corrected.

Whenever radiographic examination discloses that the position of the tooth is one which can be corrected by orthodontia, surgery should not be done. This applies to all permanent teeth with the exception of third molars.

Often surgery and orthodontia in combination can achieve the successful eruption of a tooth in cases where orthodontia alone is unsuccessful.

This latter technique is especially effective in the latent eruption of anterior teeth, which sometimes is seen in children and even adults. The technique is relatively simple and consists in exposing as much of the crown of the tooth as possible and removing any bone impediment to its eruption. The patient is instructed in inhibitory the regrowth of soft tissues over the tooth by the daily use of a sterile orange wood stick. If the tooth does not erupt of its own accord, the orthodontia treatment is instituted to hasten the procedure and to bring the tooth to its proper place in the arch.

While any of the permanent dentition may be impacted, the teeth most often affected are the third molars and cuspids. Fourth molars, when they occur, are more often impacted than not. The predisposing cause is generally the under development of the dental arch which is in turn due to several factors including adenoids and soft diet. The cuspids and third molars being among the last of the dentition to come into place are therefore the teeth most often cheated of their place in the arch.

Sometimes an impacted tooth may remain in possession for years and may never give rise to suggestive symptoms. On the other hand, they may give rise to symptoms which may be quite confusing. Pain, definite or indefinite, in various parts of the head, dizziness, sore throat, and swollen glands are among the chief suggestive symptoms. Often pain seems to originate in areas not immediately surrounding the impaction area.

The case of the third molar is often associated with local swelling, trismus, and diffuse cellulitis of the face. Pericoronal infection in this area is the most usual symptom which brings the patient to seek treatment.

The removal of an impacted tooth is most advisedly done while the tooth is quiescent and there is no evidence of any acute inflammation in the area.

continued on page 591

WELLS DINNER ON DECEMBER 11

The Society's Horace Wells Centenary Committee consisting of Drs. Edward C. Morin, James F. Colgan, and Walter F. Tompkins, has announced that a dinner to honor the memory of Dr. Horace Wells will be held under the auspices of the State Dental Society at the Narragansett Hotel on Monday, December 11, at 7 P. M. A reception starting at 6:30 P. M. will precede the dinner. Dr. Ambrose H. Lynch of Providence will deliver the address on the contribution of Dr. Wells to dental and medical science, and Dr. Harry M. Seldin of New York City will present a scientific paper on anesthesia. Dr. Frank P. Duffy of West Warwick will be toastmaster.

Every member of the Society should attend this Centenary Celebration dinner. Dinner tickets, at $3.50 each, are obtainable from the following representatives of the Society:

Dr. Charles F. McKivergan	Providence
Dr. W. A. Morinville	Pawtucket
Dr. Maurice A. Denby	Warren
Dr. Paul E. Cote	Woonsocket
Dr. Arthur Dring	Newport
Dr. Harold F. Doyle	Westerly
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PROVIDENCE

CASE AGAINST THE IMPACTED TOOTH

continued from page 589

Some of the foremost workers insist upon waiting for all acuteness to subside; but others equally capable feel that provided a wise choice of anaesthetic is used, it is permissible to remove the offender in the acute condition.

The impacted tooth is an abnormality which can cause a multiplicity of systemic disturbances as well because it is generally found to be cystic and as such, must be considered as a potential primary focus of infection.

From a medical standpoint it should not only be condemned because of its ability to ruin an otherwise normal occlusion; but also because by its intermittent activity causing pressure it can damage nervous tissue and give rise to symptoms that often defy analysis.

In summing up: Every effort should be made through adenoid removal, corrected diet, chewing exercises, and orthodontia to bring about proper expansion and development of the dental arch and thus cut down the alarming increase of impacted teeth.

In the search for focus of infection and for pain in the head, a full dental radiographic examination should be retained.

Except in the case of extraordinary contra indications, the impacted tooth should be considered a menace. At least the patient should be advised of potentialities. It should be explained that the onset of symptoms is often severe and unpleasant.

Age is not a factor. One patient I saw several years ago had an onset of violent head pains at 70 years of age. He had been wearing full upper and lower dentures for 30 years. There was a suspicion of brain tumor and a radiographic examination showed a deeply impacted cuspid, and its removal eliminated all pain.

The earlier the tooth is removed, the better, however, not only because of the advantage of earlier elimination of its potentialities but also because of the fact that the younger patient is better able to withstand the shock of surgical interventure.

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HOSPITAL CARE POLICIES OUTLINED

by American Hospital Association

THE Third War Conference of the American Hospital Association was held in Cleveland, Ohio, October 2-6, 1944.

The Association has long been concerned in having a definite statement of policy in regard to hospital care in the future. From time to time many individuals, including government agencies, have asked the officers what the position of the American Hospital Association is in regard to certain proposed policies.

The House of Delegates, therefore, adopted at this session the following official credo or statement of policy whereby the officers of the Association could determine if proposals submitted to them were in keeping with the ideals of the American Hospital Association.

"The American Hospital Association must continue to promote the best possible hospital care for the American people and to assist in making such care available to all.

"Therefore, the American Hospital Association presents the following statement of policy regarding hospital care:

I. Ideals of the American Hospital System.
   a. To render the best possible hospital care.
   b. To make hospital care readily available in all areas and to all people.
   c. To improve constantly standards of hospital care.

II. The Hospital's Responsibility as a Community Health Center
   a. Care of the sick — provision of the latest diagnostic and therapeutic services.
   b. Education — Physicians, nurses, personnel and public.
   c. Research — Medical care and hospital management.
   d. Participation in a program of preventive medicine.

III. Present program of the American Hospital Association.
   a. Preservation of the values of the voluntary hospital system.
   b. Local, county, State, and Federal government aid for the care of the indigent with emphasis on local participation.
   c. Government aid for public and voluntary hospital construction upon evidence of unmet needs.
   d. Extension of inter-hospital coordination and cooperation upon urban and rural.

The American Hospital Association realizes that the existing hospital system does not fulfill completely and perfectly the hospital needs of the American people. It urges that every hospital be alert to the needs of its community. It further recommends a careful analysis of existing deficiencies and urges action to meet them progressively.

The American Hospital Association urges that as a program is developed for the realization of universal availability of hospital care the following factors be borne in mind:

1. That it be based upon evidence of unmet needs which the changes will fulfill.

2. That it be convenient and economical, utilizing to the greatest possible degree existing resources, motives and organizations.

3. That consideration be given to all other factors which affect individual and public health.

4. That the program of evolution attack the most pressing problems.

The American Hospital Association warns against decisions based primarily upon administrative expediency and therefore believes that as in other forms of human endeavor continued improvements can and will be made in hospital service for the American people. In all these matters so vitally affecting the well-being of the population, great caution should be taken at the same time to preserve American tradition and the spirit of individual initiative and enterprise.

As submitted by the Special Committee of the House of Delegates:

STUART HUMMEL, *Chairman*
R. C. BUERKI, M.D.
GUY J. CLARK
JAMES A. HAMILTON
JOHN F. MCCORMACK

CASH SICKNESS FUND ILLNESS CLAIMS

(Preliminary analysis of types of illnesses for which claims were filed against Cash Sickness Fund from April 1, 1943 to March 31, 1944)

HUGH J. HALL, M.D.
Medical Director, R. I. Cash Sickness Compensation Fund

THE statistical tables presented below give a preliminary analysis of the types of diseases and illnesses for which persons filed claims against the Rhode Island Cash Sickness Fund during the benefit year starting April 1, 1943 and ending March 31, 1944. I wish to point out, however, that these are estimates that are subject to revision. In the final analysis, which will be completed in the near future, we believe the various totals will be increased from five to nine per cent. Also in the process of compilation at this time are statistics indicating the duration of the various types of illness and when this data is available I hope that it may be publicized in the MEDICAL JOURNAL.

TABLE 1. — *Distribution of Claimants for Cash Sickness Benefits by Medical Diagnosis, Marital Status and Sex.*
FIRST BENEFIT YEAR — April 1, 1943 - March 31, 1944

	Grand Total	Male			Female		
		Total	Married	Single	Total	Married	Single
Grand Totals	33581	14987	12099	2888	18594	14124	4470
INFECTIOUS AND PARASITIC DISEASES	746	469	335	134	277	145	132
typhoid fever and dysentery	7	4	4	***	3	2	1
Childhood diseases, measles, mumps, etc.	76	34	27	7	42	20	22
tuberculosis — various forms of	397	273	183	90	124	68	56
Gonococcus infection — various forms	3	3	1	2	.....	.....	.....
malaria — various forms of	.....	.....	.....	.....	.....	.....	.....
syphilis — various forms of	23	17	13	4	6	3	3
other infectious and parasitic diseases	240	138	107	31	102	52	50
NEOPLASMS (Tumors, Cysts, etc.)	549	285	228	57	264	190	74
malignant neoplasms, types of	241	164	132	32	77	58	19
non-malignant neoplasms, types of	308	121	96	25	187	132	55
RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS AND NUTRITION AND OTHER GENERAL DISEASES	680	208	163	45	472	326	146
Acute rheumatic fever, forms of	126	54	43	11	72	42	30
endocrine glands — various diseases of	479	129	101	28	350	251	99
Nutritional and other general diseases	75	25	19	6	50	33	17
DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS	499	74	60	14	425	303	122
anemia — various forms of	489	69	58	11	420	298	122
other blood and blood organ diseases	10	5	2	3	5	5	.....
CHRONIC POISONING AND INTOXICATION	6	5	4	1	1	.....	1
alcoholism, lead, drug, other chronic	6	5	4	1	1	.....	1
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	2498	944	760	184	1154	1116	438
neural diseases — various forms of	757	446	372	74	311	238	73
mental disorders — various forms of	1357	300	226	74	1057	770	287
organs of vision — various diseases of	287	163	134	29	124	69	55
ear and mastoid process — diseases of	97	35	28	7	62	39	23

	Grand Total	Male			Female		
		Total	Married	Single	Total	Married	Single
DISEASES OF THE CIRCULATORY SYSTEM	3288	1754	1463	291	1534	1201	333
heart disease — various forms of	1510	947	795	152	563	422	141
arteries — various diseases of	884	414	336	78	470	382	88
veins — various diseases of	657	317	272	45	340	277	63
other circulatory system diseases	237	76	60	16	161	120	41
DISEASES OF THE RESPIRATORY SYSTEM	5170	2673	2210	463	2497	1519	978
influenza	1588	802	674	128	786	472	314
common cold	121	50	33	17	71	41	30
tonsilitis with tonsillectomy	49	19	12	7	30	16	14
larynx & pharynx — various diseases of	519	213	176	37	306	159	147
bronchitis — various diseases of	1095	545	455	90	550	347	203
pneumonia — various forms of	1030	650	541	109	380	226	154
other respiratory system diseases	768	394	319	75	374	258	116
DISEASES OF THE DIGESTIVE SYSTEM	4100	2374	1918	456	1726	1023	703
mouth & esophagus — diseases of	83	27	23	4	56	25	31
ulcers of stomach & intestines	658	525	439	86	133	102	31
diarrhea and enteritis	238	93	76	17	145	98	47
appendicitis — various forms of	880	319	240	79	561	197	364
hernia — various forms of	966	900	723	177	66	51	15
nervous indigestion	121	29	22	7	92	64	28
other stomach and intestinal diseases	501	277	223	54	224	134	90
liver & gall bladder — diseases of	629	199	169	30	430	345	85
other digestive system diseases	24	5	3	2	19	7	12
Grand Totals	2554	419	333	86	2135	1804	331
DISEASES OF THE GENITO-URINARY SYSTEM							
kidneys & ureters — diseases of	489	213	172	41	276	218	58
other urinary system diseases	61	29	23	6	32	26	6
male genital organs — diseases of	177	177	138	39			
female genital organs and breast	1827				1827	1560	267
DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, THE PUERPERIUM	4333				4333	4257	76
pregnancy — and complications of	4333				4333	4257	76
DISEASES OF THE SKIN	659	387	293	94	272	159	113
skin diseases — eczema, impetigo, etc.	659	387	293	94	272	159	113
DISEASES OF THE BONES AND ORGANS OF MOVEMENT	1997	1044	846	198	953	712	241
arthritis — various forms of	1364	678	570	108	686	550	136
other bone, joint & muscular diseases	633	366	276	90	267	162	105
CONGENITAL MALFORMATIONS	12	10	2	8	2	1	1
congenital malformations, types of	12	10	2	8	2	1	1
DISEASES PECULIAR TO THE FIRST YEAR OF LIFE	2	1	1		1	1	
injury at birth, prematurity, etc.	2	1	1		1	1	
OTHER AND ILL-DEFINED DISEASES	951	382	286	96	569	360	209
lumbago, neuralgia, nervousness, etc.	688	259	209	50	429	286	143
all other diseases	263	123	77	46	140	74	66
ACUTE POISONINGS AND INJURIES	5535	3956	3195	761	1597	1007	572
acute poisoning — food acid, drug, etc.	21	15	12	3	6	4	2
injury by foreign body, concussion, etc.	139	106	83	23	33	21	12
compound fracture injuries	1130	861	697	164	269	176	93
simple fracture injuries	568	441	343	98	127	66	61
dislocation, sprain, etc. no fracture	1466	966	789	177	500	367	133
burn or scald injuries	188	131	102	29	57	30	27
cut laceration, or puncture injuries	463	346	257	89	117	66	51
superficial injuries — abrasions, etc.	452	309	256	53	143	87	56
other or unspecified injuries	1108	781	656	125	327	190	137
OTHER CONDITIONS	2	2	2				
Diagnosis not recorded							
Marital status not recorded							

continued on page 597



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TABLE 2. — *Distribution of Male Claimants by Age Groups and Types of Sickness*

FIRST BENEFIT YEAR — April 1, 1943 - March 31, 1944

General Classification of Sickness	Total	Under 16 yrs.	16-20	21-25	26-30	31-35	36-40	41-50	51-60	61 yrs. and over
Total No. of Claimants	14987	1	537	556	1129	1275	1422	3207	3334	2645
Total Cases — Data available	14106									
Total Cases — Data not available	881									
INFECTIOUS AND PARASITIC DISEASES	441		41	30	58	61	48	93	69	41
age data not available	28									
NEOPLASMS	273		6	14	13	4	24	52	71	89
age data not available	12									
RHEUMATIC FEVER, DISEASES OF the endocrine glands nutrition and other general diseases	198		7	13	16	12	23	37	49	41
age data not available	10									
DISEASES OF THE BLOOD AND BLOOD FORMING ORGANS	68			4	2	3	2	14	18	25
age data not available	6									
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDER	897		15	32	53	82	67	211	250	187
age data not available	47									
DISEASES OF THE CIRCULATORY SYSTEM	1661		15	14	38	62	82	289	504	657
age data not available	93									
DISEASES OF THE RESPIRATORY SYSTEM	2504		77	79	184	195	271	622	630	446
age data not available	169									
DISEASES OF THE DIGESTIVE SYSTEM	2235		121	110	188	223	266	581	472	274
age data not available	139									
DISEASES OF THE GENITO-URINARY SYSTEM	398		12	11	20	31	35	65	119	105
age data not available	21									
DISEASES OF THE SKIN	370		22	15	34	39	47	84	75	54
age data not available	17									
DISEASES OF THE BONE AND ORGANS OF MOVEMENT	986		19	38	62	90	81	227	254	215
age data not available	58									
CONGENITAL MALFORMATIONS	8		4		1		1		2	
age data not available	2									
DISEASES PECULIAR TO THE FIRST YEAR OF LIFE	1									
age data not available										
OTHER DEFINED DISEASES	333		13	13	28	28	28	63	89	71
age data not available	49									
ACUTE POISONINGS AND INJURIES	3726	1	185	183	430	444	446	866	732	439
age data not available	230									
OTHER CONDITIONS	2				1	1				
CHRONIC POISONING AND INTOXICATION	5									
age data not available										

continued on page 599

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MEMORANDUM FROM: Medical Director
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TABLE 3. — *Distribution of Female Claimants by Age Groups and Types of Sickness*

FIRST BENEFIT YEAR — April 1, 1943 - March 31, 1944

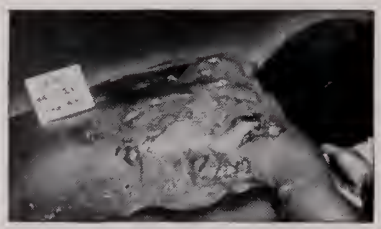
General Classification of Sickness	Total	16-20	21-25	26-30	31-35	36-40	41-50	51-60	61 yrs. and over
Total No. of Claimants	18,594								
Total Cases — Data available	17,540	1493	2991	2739	2398	2225	3551	1677	466
Total Cases — Data not available	1,054								
INFECTIOUS AND PARASITIC DISEASES	257	46	48	44	25	31	33	26	4
age data not available	20								
NEOPLASMS	251	12	15	21	33	36	101	23	10
age data not available	13								
RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS, NUTRITION AND OTHER GENERAL DISEASES	441	35	52	54	75	71	86	56	12
age data not available	31								
DISEASES OF THE BLOOD AND BLOOD FORMING ORGANS	402	38	68	62	66	55	74	31	8
age data not available	23								
CHRONIC POISONING & INTOXICATION	1	.....	1	.....	.....	.....	.....	.....	.....
age data not available	.....								
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	1464	73	191	218	229	237	312	154	50
age data not available	90								
DISEASES OF THE CIRCULATORY SYSTEM	1461	35	65	103	154	178	456	325	145
age data not available	73								
DISEASES OF THE RESPIRATORY SYSTEM	2365	161	303	285	334	375	570	271	66
age data not available	132								
DISEASES OF THE DIGESTIVE SYSTEM	1626	271	259	202	213	224	274	154	29
age data not available	100								
DISEASES OF THE GENITO URINARY SYSTEM	2003	70	153	230	266	324	778	168	14
age data not available	132								
DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, THE PUERPERIUM	4130	515	1497	1168	633	265	51	1	.....
age data not available	203								
DISEASES OF THE SKIN	260	41	25	32	33	36	63	29	1
age data not available	12								
DISEASES OF THE BONE AND ORGANS OF MOVEMENT	897	38	62	83	87	117	284	177	49
age data not available	56								
CONGENITAL MALFORMATIONS	2	.....	.....	.....	1	1	.....	.....	.....
age data not available	.....								
DISEASES PECULIAR TO THE FIRST YEAR OF LIFE	1	.....	.....	.....	.....	.....	1	.....	.....
age data not available	.....								
OTHER & ILL DEFINED DISEASES	497	30	74	71	78	66	116	47	15
age data not available	72								
ACUTE POISONINGS & INJURIES	1482	128	178	166	171	209	352	215	63
age data not available	97								



Uses of Fiberglas in Medicine*

Physicians, surgeons and others engaged in medical research have, in recent years, employed various Fiberglas materials experimentally and have found them uniquely fitted for certain uses.

For example, Fiberglas cloth (ECC-11-108) was used to help measure the protein loss in the exudate from surface burns. As illustrated, the Fiberglas cloth was placed next to the burned skin of a 12-year-old Negro girl. It is the first layer of a bandage devised to collect the exudate in order accurately to measure nitrogen loss from the burned skin surface. The patient was admitted to a Detroit hospital in January, 1944. The burn, caused by hot water, involved about 12 per cent of the body surface. "The burn healed rapidly," says the report in *Surgery*, "and the amount of nitrogen lost in the exudate from the burned area diminished as healing progressed."



This method of determining the magnitude of the protein loss from the burned surface gives physicians a comprehensive picture of the metabolic upset for the first time and thus will permit improved replacement therapy.

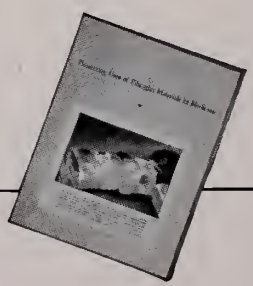
Fiberglas is glass in fiber or filament form. Glass textile fibers, ranging in diameter from four ten-thousandths of an inch to less than two ten-thousandths of an inch are formed into yarns which are woven into a wide variety of textiles.

Fiberglas is an inorganic, nontoxic, nonallergenic, nonsensitizing and chemically stable substance which produces no harmful effect upon human tissue. It is pliable and possesses great tensile strength. It has high dimensional stability, resists high temperatures, steam, corrosive fumes and acids (except hydrofluoric). Fiberglas is nonhygroscopic and noninflammable. It is easily sterilized and resterilized, and in a special form is radiopaque.

It is the policy of Owens-Corning Fiberglas Corporation to supply samples of Fiberglas in any available form to qualified persons engaged in research. The new brochure describing such other pioneering uses of Fiberglas as:

- Tracer Threads in Surgical Sponges
- Experimental Surgical Sutures
- Culture of Microorganisms
- Blood Plasma Filters
- Air-borne Bacteria Control
- Pollen and Dust Control
- Penicillin Production
- Insulation of Autoclavable Closed Motors
- Fiberglas-Plastic Artificial Limbs

. . . may suggest ways in which Fiberglas can help solve other problems. Ask your secretary to send for your copy today. Write Owens-Corning *Fiberglas Corporation, 2036 Nichalas Bldg., Toledo 1, Ohio.*



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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., *Chairman*; Stanley Davies, M.D.; Arthur E. Martin, M.D., Elihu S. Wing, M.D., William P. Buffum, M.D.

THE HANDICAPPED VETERAN IN INDUSTRY

The return of the physically handicapped veteran from military to civil life will present a problem to industry. The industrial physician will do well to consider plans to provide employment for such men. Now is the time to consult with Management, Personnel Directors and other officials in planning for the use of handicapped veterans.

Industrial physicians should suggest plant studies and surveys to determine the type of jobs that can be handled by persons with major or minor defects, such as the loss of one or both arms or legs, the loss of one eye or of hearing. The industrial physician can help materially by setting up physical standards for the employment of veterans in the specific jobs of the plant. In order to do this the physician must be thoroughly familiar with all operations within the plant—the type of procedures involved—the hazards—and the measures needed to correct such hazards.

Speaking in Boston recently, Dr. C. O. Sappington, editor of "Industrial Medicine", stressed the necessity for "plant walks" similar to ward walks in the hospital. He urged industrial physicians to get out into the plant, make a survey of existing conditions, offer suggestions for correction and be alert to hazards and their prevention. "We are an industrial nation," he stated, "why haven't we made greater advance in the field of industrial health?"

With the return of the veteran to civil life, the industrial physician will be expected to have a great deal to say regarding his placement and his welfare in industry. Now is the time to prepare! We urge industrial physicians to take up the problem with Management at the earliest possible moment and look around their plants to see wherein they can be of service in placing handicapped veterans where they will be most useful and most happy.

SMALL PLANT MEDICAL DEPARTMENTS

To those physicians who go to plants only on call, the Committee on Industrial Health of the State Medical Society offers its services in establishing a small plant Medical Department if desired.

We believe that even small plants should have an adequately equipped first-aid room and, wherever possible, the services of a nurse even if it is the visiting nurse instead of a full-time employee. We would like to arrange for one physician to cover a series of small plants. If we can interest Management of adjacent or nearby small plants in its establishing first-aid rooms or a community first-aid room with the services of a nurse, we feel that we can materially assist in establishing a health program. Representatives of the Division of Industrial Hygiene in the State Department of Health and members of this committee would like to meet the superintendent or manager of the plant, the president of the company, or some other official, as well as the personnel man, the director of the safety committee, a representative of the employees and first-aid man if one is available. We welcome inquiries regarding this plan.

Fellowship in Industrial Medicine

A Fellowship in Industrial Medicine has been established in the University of Pittsburgh School of Medicine, Department of Industrial Hygiene, by a grant of $2500.00 from a James S. Kemper Foundation. The purpose of the fellowship is to give post graduate work to physicians desiring to enter Industrial Medicine. For further information, apply to Dr. William S. McEllroy, Dean of the University, Pittsburgh, Pa.

Cold Vaccines Again

Now that the fall season is with us manufacturers of cold vaccines have again attempted to interview industrial Management in an effort to interest them in promoting the distribution of cold vaccine capsules among the employees. We reviewed the subject of cold vaccines last year. We would not mention it again except for the fact that one company promoting the use of cold vaccine in industry has been submitting testimonials as to its efficacy from such uninformed and unscientific sources as a chief of police, a personnel director, the vice president of a corporation, a safety director and an employee service director. We consider it an insult to our intelligence that any pharmaceutical house would ask us to consider as evidence the unscientific opinions of laymen as to the efficacy of a controversial pharmaceutical in the field of health. Medicine moves forward on the basis of scientific evidence not on the opinions of the laity.



TOWARD THE GOAL THAT ALL WHO NEED IT MAY HAVE IT...

PENICILLIN *Schenley*



TODAY on all our battlefronts many an Allied soldier owes his life to the fact that penicillin is now being produced in sufficient quantities to meet the most important military needs. And as military needs are more fully met, there will be increasing amounts of penicillin available for civilian use.

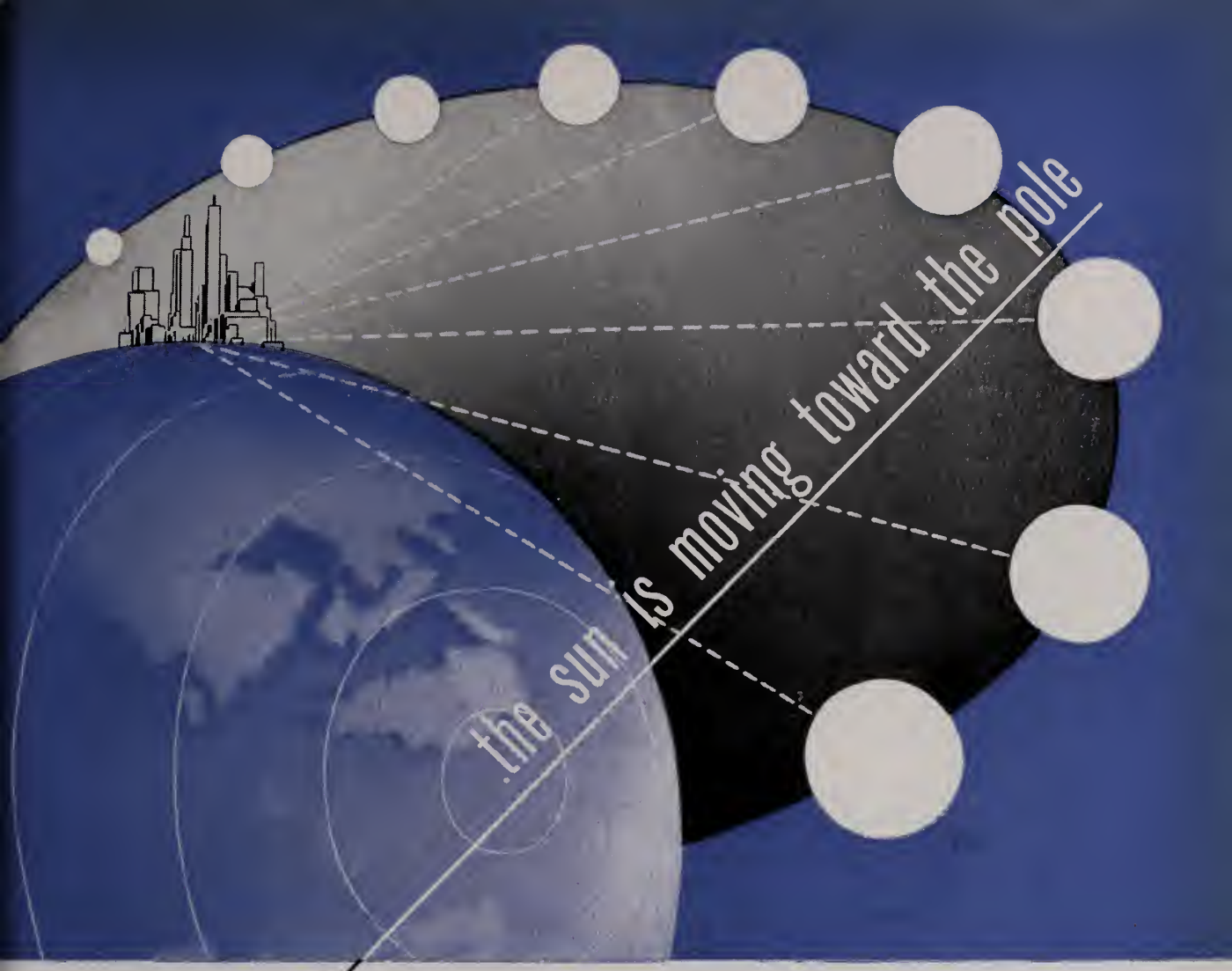
Contributing to this accomplishment have been the resources of 21 firms appointed by the Government to produce the precious new drug.

Schenley Laboratories, Inc., are proud to be among those chosen to attack the almost insuperable technical difficulties in the manufacture of penicillin. The devotion of our facilities to this purpose is a natural outgrowth of the extensive research in mycology Schenley Laboratories have been conducting for many years.

We are glad to be working wholeheartedly toward the goal that... in the near future... all who need penicillin may have it.

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and with it, the benefits to your patients of solar ultraviolet,

source of vitamin D.

"It has been calculated that in the temperate latitude, exposure during the whole day in Winter would be required to be effective, and that in many parts of that zone no effective radiation occurs after 3 p.m. in Winter."*

However, there is an easy as well as economical method of assuring an adequate intake at all times of vitamin D together with its close partner in Nature—vitamin A.

WHITE'S COD LIVER OIL CONCENTRATE

contains the natural vitamins of time-proved cod liver oil, in concentrated potency, free from excess oily bulk.

A single tablet or two drops of the Liquid provides the vitamin A and D potency of a teaspoonful of cod liver oil**—and with very notable economy. Liquid, Tablet and Capsule dosage forms.

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*Youmans, J. B.: Nutritional Deficiencies, Lippincott, New York, 1941.

**U. S. P. Minimum Requirements.

White's PRESCRIPTION *vitamins*

Not Lances, but a *Lancet*



He's a man of battle. He doesn't charge in with lance atilt—or its modern equivalent the bayonet, the Tommy gun, the Garand—but he's fighting for life, all the same. The lives of other men... and constantly at the risk of his own in those advanced dressing stations and field hospitals. Bombs lash down... shells burst... but he stays at his post.

Once in a while he has a moment to himself. A moment of relaxation... time for a cigarette... time for a Camel. With men in all the services, Camel is the favorite according to actual sales records.

COSTLIER TOBACCOS **Camels**

Reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.



MEMORIES OF 1918

As the twenty-sixth anniversary of the Armistice of World War I arrives while the nations of the world continue to fight for the finish of World War II we paused to review the happenings of 1918 as viewed in the issues of the Rhode Island Medical Journal of that year. The similarity in the reporting of events of that day with the present day announcements is striking.

In May, 1918, the Journal editorially stated that "unless this country puts forth every ounce of its strength in all lines of endeavor we shall be forced by a German victory to pay an indemnity beside which our present income taxes and Liberty Loan subscriptions would pale into insignificance."

On April 8 Captain Fenwick G. Taggart, now vice president of the Society, and Captain Joseph Hawkins, then business manager of the Journal, were reported as leaving for service at Fort Oglethorpe. The first war casualty was reported in the untimely death of Dr. Peter L. Keough of Pawtucket. Commissioned a Lieutenant shortly after the United States entered the war, Doctor Keough soon won his captaincy. He contracted pneumonia while on duty at Camp Sherman in Ohio, and the illness proved to be fatal on April 15.

Unit Organized

In mid-May nine of the doctors assigned for duty with the Navy Base Hospital, Unit 4, left for preliminary instruction at Newport. In this first group were Lieutenants (senior grade) L. C. Kingman, W. H. Buffum, and A. A. Barrows, and Lieutenants (jg) Alex M. Burgess, Paul Cook, Elihu S. Wing, Frank H. Mathews, and Henry L. Johnson. Later others, including Lt. Comdr. Halsey Dewolf, Lt. Comdr. George Matteson, Lieutenants (s) Roland Hammond, F. V. Hussey, Joseph C. O'Connell, Lewis B. Porter, C. S. Westcott, and Lieutenants (jg) William P. Buffum, Jr. and George Eckert, of Newport, were listed to join the Unit.

Appealing for medical volunteers for the Army, Surgeon General W. C. Gorgas was quoted in the May issue of the Journal as stating "we are now entering the fighting phase of the war . . . by the end of the year a million and a half men will be in France. Fifteen thousand medical officers will be required for that Army alone. There are on duty today 15,174 officers of the Medical Reserve Corps."

Physical Defects of Inductees

At the May meeting of the Providence Medical Association in 1918, Dr. George S. Mathews, speaking on "Some Cardio-Vascular Considerations in Connection with Advisory Draft Board Examinations", summarized with conclusions strangely familiar to us in 1944. He stated that "The statistics that are accumulating in regard to registrant examinations will be illuminating. In an analysis of some 9,000 cases one writer noted that 29% were rejected on physical grounds. Eyes, teeth, weight, in the order named, were the largest contributing causes. The heart was responsible for about 2½% of rejections. It is stated by competent observers that in a population of military age between 19 and 45 about 50% would be found disqualified. This is startling and, if true, calls for radical reform in the hygienic education of the people in the overcoming of much preventable physical deficiency. In the words of Kipling:

'It ain't the individual,
Nor the army as a whole,
But the everlastin' team work
Of every bloomin' soul'."

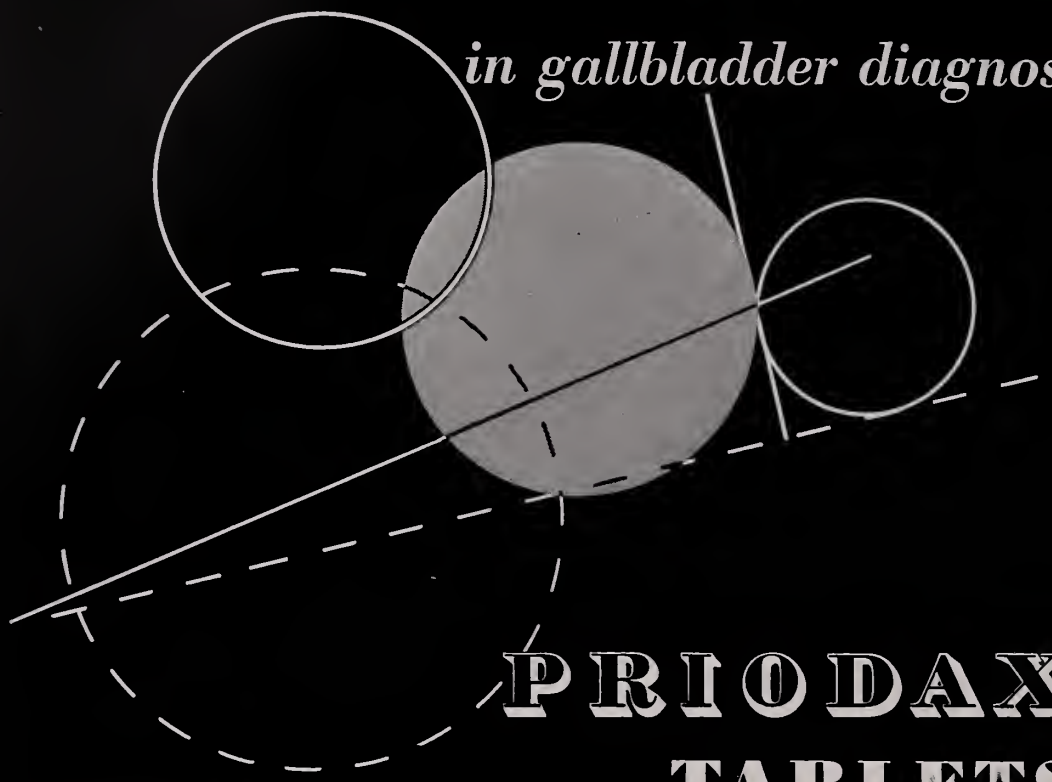
Enlistments

In his presidential address, read before the Society on June 6, Dr. John Champlin of Westerly relates that 137 of the 751 physicians in the State have enlisted for duty with the armed forces, with 118 serving with the Army and 19 with the Navy.

continued on page 607

EXACTNESS

in gallbladder diagnosis



PRIODAX TABLETS

The Unique* Gallbladder Medium

Simply and easily administered
Safe and well tolerated
Provides clear, dependable cholecystograms
Obviates confusing intestinal shadows
Offers greater diagnostic accuracy

* PRIODAX is not a phenolphthalein derivative. It is beta-(4-hydroxy-3,5-diiodo-phenyl)-alpha-phenyl-propionic acid.

PRIODAX supplied in cellophane envelopes, containing 6 tablets. Boxes of 1, 5, 25 and 100 envelopes.

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MEMORIES OF 1918

continued from page 605

On June 3, Dr. G. A. Blumer called attention at the meeting of the Providence Medical Association to the Red Cross drive for nurses, and he asked for the assistance of the members in securing the quota for Rhode Island. On June 6, Lt. Comdr. John C. DaCosta, surgeon in the USNRF, addressed the Society on the "Medical Activities of the Navy".

Rehabilitation

In an editorial in the June issue we find the following observation regarding scientific medicine and the war which strikes a responsive chord as we now talk of rehabilitation plans for veterans: ". . . with the establishment of reconstruction centers, each having a physio-therapeutic plant for treatment, curative workshops and trade schools, and with the cooperation of federal employment bureaus, the man will be guided and taught until he is self-supporting. It is encouraging to feel that the cripples of the present war will not be allowed to drift and to fill our institutions with derelicts as in previous wars, but will become respectable and self-supporting citizens."

Personals

July 1918. The Society proudly records that "one of its members, Lieut. Bertram H. Buxton, serving with our forces in France, has been awarded the Medal of Honor for bravery under fire."

Captain Herman C. Pitts and Captain John B. Ferguson have been ordered to Philadelphia to receive special instruction in brain surgery.

Lieut. Anthony Corvese has arrived safely "somewhere in France" where he states there are many chateaux and gardens.

Captain Frank M. Adams has been commissioned and is awaiting orders for nose and throat work.

BEGINNINGS OF THE EMIC?

In the August issue appeared a brief review of the booklet titled "CHILD CARE". In the comment the following is noted:

"Things every mother must know if the nation is to meet the health needs of its children as indicated by the draft and still further revealed by the weighing and measuring test have been made available recently by the Children's Bureau of the U. S. Department of Labor in its new bulletin on Child Care, prepared by Mrs. Max West.

"CHILD CARE has been prepared in the hope that it would enable mothers to understand and recognize symptoms which indicate the need of special care . . ."

"CHILD CARE . . . is the third issue in the series which began with PRENATAL CARE and INFANT CARE . . ."

Play Safe

Every doctor knows the value of Homogenized Milk. And every doctor should know that A. B. MUNROE DAIRY GRADE A HOMOGENIZED MILK is a quality product because it is processed under the most stringent laboratory control.

It is delicious, easier to digest, and tops in nutritive value.

You play safe when you prescribe A. B. Munroe Grade A Homogenized Milk!

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DISTRICT SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 2, 1944.

The meeting was called to order by President Albert H. Jackvony at 8:30 P. M.

The President announced that since the minutes of the last meeting had been published in the RHODE ISLAND MEDICAL JOURNAL the reading of them would be omitted unless there was objection.

The Secretary reported the receipt of a communication from Dr. Lewis T. Bennett, Medical Director of the Walsh-Kaiser Company shipyard in Providence, asking for assistance in securing local doctors interested in part time work at the shipyard.

The Secretary reported the receipt of a communication from the Public Service Publications calling attention to the numerical telephone list for 1944-45. This publication lists the telephone number for nearly the entire state in numerical sequence and attention is directed to it because of its possible interest and value to the members of the Association. The Secretary reported that a copy of the publication was available at the Executive Office for any doctor interested in viewing it.

The President reported that the Committee of Dr. Roland Hammond and William O. Rice had submitted the Association's tribute to the late Dr. Nathaniel H. Gifford, and the Committee of Dr. Herbert Partridge and Charles O. Cooke had submitted the Association's tribute to the late Dr. William Bryant Cutts.

The President introduced Mr. Covell, Division Representative of E. R. Squibb & Sons who briefly outlined the background for the new motion picture in sound on "Nutrition" produced by his company. After this explanation Mr. Covell showed the picture.

Two representatives of E. R. Squibb & Sons, Mr. Covell and Mr. Goulding presented an interesting forty-minute film on nutrition. The content included talks by several experts giving details, illustrated by pictures of patients, of the diagnosis and treatment of numerous nutritional deficiencies. The film was of definite educational value.

Dr. Joseph F. Hawkins made some remarks on the history of efforts to transplant pieces of cornea to take the place of excised opaque corneal tissue. A film was then presented showing the operative technique of Dr. Ramon Castroviejo. Dr. Castroviejo has done more than anyone to advance the technique and improve the results obtained by this operation. Pictures of patients were included who had corneal transplantations remaining clear for as long as one to ten years. Questions were asked from the floor which Dr. Hawkins answered.

The President introduced Mr. William L. Connolly, State Director of labor under whose jurisdiction the new State Rehabilitation Center is to be operated. He explained briefly the origin and the law covering the setting up of the curative center under the direction of the Department of Labor. Dr. John Donley, who has been made Director of the Curative Center, also discussed the matter. Both gentlemen answered numerous inquiries from the members present.

The meeting adjourned at 11:00 P. M.

Attendance 55.

Respectively submitted,
FRANK W. DIMMITT, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The first fall meeting of the Pawtucket Medical Association was held in the Nurses' Auditorium of the Memorial Hospital on September 21, 1944 at 12 noon.

After a short business meeting the speaker of the day, Dr. Stanley Sprague, was introduced by the president, Dr. Edward Trainor. Dr. Sprague spoke on "Headaches from the Cash Sickness Benefit Program", and gave a very interesting talk. He presented his subject from the point of view of an examining physician of the Compensation Board and pointed out that there were just as many difficulties to be surmounted by the examining board as there were by the family physicians. After a short but spirited discussion period the meeting was adjourned.

The October meeting of the Pawtucket Medical Association was held at 12 noon, October 19, 1944, at the Memorial Hospital. The meeting was called to order by the president, Dr. Edward Trainor. It was decided to continue the weekly radio talks and Dr. Stanley Sprague, chairman of the radio committee, was requested to complete arrangements


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In the correction of the anemic state Livitamin not only leads to rapid hemoglobin regeneration, but also aids in the eradication of the usually associated conditions. Its iron is highly available and promptly utilized; its contained liver concentrate presents the fractions found valuable in the anemias; its rich store of B-vitamins overcomes the frequently severe anorexia and corrects the nutritional deficiencies which almost invariably are encountered in hypochromic anemia. Since Livitamin is in liquid form, dosage is easily adjusted to the patient's need. Its palatable taste is appreciated by all patients, and especially by children.

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Each fluidounce of Livitamin presents:

Fresh liver (as liver concentrate)	2 oz.
Thiamine Hydrochloride (B_1) (3 mg.)	100 U.S.P. Units
Riboflavin (B_2,G)	1 mg.
Nicotinamide (niacinamide)	25 mg.
Pyridoxine hydrochloride (B_6)	1 mg.
Pantothenic acid	5 mg.
Filtrate factor	20 J. L. Units
Iron and manganese peptonized	30 grains

In doses of 2 to 4 teaspoonfuls t.i.d. Livitamin rapidly corrects hemoglobin deficiency. Available in 8-oz. bottles.

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with the local station. Dr. Charles Farrell's recent publication in the Providence Bulletin in regard to socialized medicine was discussed and the Society commended Dr. Farrell upon the excellence of his article; it was voted that the article be sponsored by the society for further publication and distribution.

The speaker of the day, Miss Mary Nunez, R.R.L., of the Memorial Hospital, was introduced by the president. Her paper entitled, "The Medical Record—Its Importance to the Hospital and the Physician", was interesting and enlightening. She stressed the fact that inaccurate and incomplete records are of little value to anyone, whereas accurate, complete records may be used to further medical science, to further the physician's knowledge, and to protect the patient and to assure him that proper medical care is being rendered. She stated that, "From the medical record, the medical staff and administration of the hospital are able to analyze the quality and quantity of the work which has been done. It enables them to study the immediate results such as deaths, improved or unimproved cases. If death ensues, search for the cause can be made and may result in the elimination of causes that may be preventable. If a patient is improved on discharge, what contributed to the improvement is important. If not improved it is still more necessary to find out the reason. These results should justify the expenditure. The hospital is responsible for knowing the exact results obtained and the reasons. In this manner, the hospital protects its reputation and its ability to render the best services that its staff and facilities will permit." She pointed out that the record is necessary for the protection of the hospital and the physician in case of medico-legal action, and cited several interesting court cases in which hospital records were used as evidence. In concluding, she again stressed that hospital records do serve a specific usefulness depending upon their completeness and accuracy and that the hospital and physician may find numerous uses for them.

Luncheon was served, after which the meeting was adjourned.

Mary-Elaine J. Rohr, M.D.

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in the Respiratory and Circulatory Emergencies of Intravenous Barbiturate Anesthesia
inject Metrazol
COUNCIL ACCEPTED
1 to 3 cc. and repeat
intravenously, intramuscularly, subcutaneously
Ampules 1 and 3 cc., tablets, solution, powder
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In the Management of Severe Third-Degree Burns

much has been learned through the unfortunate occurrence of the Cocoanut Grove fire at Boston. The numerous reports in the medical press emphasize the need for large amounts of dietary protein of adequate biologic value, given as early as possible.* Meat is one of man's main sources of protein that can be eaten with relish several times daily in goodly quantities; its proteins are of highest quality, and it contributes to the satisfaction of the greatly increased vitamin requirements as well.

*"All the patients with ten per cent of surface area, or more, involved in third-degree burns became serious nutritional problems. . . . All patients were started on high protein, high vitamin diets. . . . This diet contained 140 Gm. of protein." (Clowes, G. H. A., Jr.; Lund, C. C., and Levenson, S. M.: The Surface Treatment of Burns, Ann. Surg. 118:761 [Nov.] 1943.)

". . . at least from 200 to 300 grams of protein is needed for replacement alone. One must give the patient as much food as he can take . . . give him a good protein, one that contains all of the essential amino acids." (Elman, R.: Physiologic Problems of Burns, J. Missouri M. A. 41:1 [Jan.] 1944.)



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Nutrition

Nutritive failure is concomitant in many, if not most, disease states. It must be considered as a leading factor in convalescence, where its purpose is to repair the damage to the nutritive system and restore it to its proper state.

Four Essentials for Therapy in Nutritive Failure

1. **DIET:** 4,000 calories, 150 gram protein, rich in vitamins and minerals.
2. **BASIC THERAPY:** Thiamine, riboflavin, niacinamide, ascorbic acid, orally.
3. **ADDITIONAL MEDICATION:** Synthetic vitamins as indicated, orally or parenterally.
4. **NATURAL B COMPLEX:** Brewers' Yeast or extract, or rice bran extract, and/or liver extract orally or parenterally.

For basic therapy, Squibb Basic Formula Vitamin Tablets provide the factors for intensive therapy.

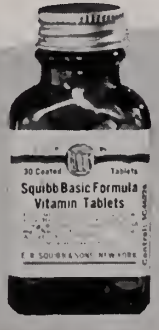
Each tablet contains:

10 mg. Thiamine Hydrochloride
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This preparation has a background of proved clinical value. It is the basic formula used by Drs. Norman Jolliffe and T. D. Spies and described by the latter in his paper on Nutritional Rehabilitation of 100 American workers for Industry.

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Sold to druggists in bulk. In stock packages. Prescribe as few or as many packages as may be needed. The cost per tablet is surprisingly low.

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Red Blood Cells Daily

Normally, the hematopoietic system is charged with the replacement of an estimated trillion red blood cells that are lost daily! The bone marrow must counteract this internal blitzkrieg. It must have raw materials: iron, protein, vitamin B-complex, the "anti-pernicious anemia factor," etc.

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Report of The Committee on
UNIVERSITY, HOSPITAL, and MEDICAL SOCIETY RELATIONS

The Committee on University, Hospital, and Medical Society Relations met with its Advisory Council on Thursday, September 21, 1944 at 8:30 P. M. in the Rhode Island Medical Library. The Advisory Council is made up of one representative from each of the regional medical societies and one from each hospital in Rhode Island. No representative was present from Washington County Medical Society or from Woonsocket Medical Society. With the single exception of Westerly Hospital every hospital was represented.

The committee submitted to the Advisory Council the following specific proposals:

(1) That hospitals reorganize their staffs and their plans for teaching programs as suggested with especial emphasis on duties of the consulting staff.

(2) That all hospitals plan to increase their interne and resident staffs to afford better study and treatment of their patients. Under this heading it is specifically suggested that those hospitals who have no internes plan to hire a paid house officer, preferably for a short appointment with frequent turn over. It is suggested that as internes graduate from the larger hospitals they will readily be available for such appointments.

(3) That a Rhode Island Medical Society faculty be organized to be available to present a variety of subjects at meetings — as they may be requested by hospitals or county societies. This arrangement would leave the county societies, hospitals or other groups free to plan their own programs and to request the services of such members of the faculty as they might wish to hear. A list of the faculty and the subjects they were prepared to present would be sent to the hospitals and county societies every year and schedules would be arranged by a committee in charge with a view to meeting all requests as far as possible.

(4) That further studies as to the possibility of a pathological institute, or some similar cooperative organization, be made in the hope that the opportunities for complete laboratory service for all hospitals be increased as far as possible.

(5) That Brown University be specifically requested to study the possibility of offering courses of the type mentioned for the benefit of members of the Rhode Island Medical Society.

After introductory discussion of these proposals by Dr. Burgess and Dr. Clarke there was lively and interesting discussion by all present. Dr. Burgess then called for a vote on the following points:

(1) Should the Committee go ahead on its study for a plan for internships?

(2) Should the Committee plan for a Rhode Island Medical Society faculty to consist of anyone who has any contribution to make, with the Committee urging outstanding men and teams to enroll?

(3) Shall the Committee initiate a further study for an Institute of Pathology?

(4) Shall the university and colleges of the state be requested to study the possibility of offering special courses and lectures for the medical profession?

Unanimous approval was given to each of these proposals.

The committee now submits these same recommendations to the House of Delegates. If your approval is forthcoming we propose to continue our studies along these lines in the hope of arriving at specific and detailed recommendations.

B. Earl Clarke, M.D., *Chairman pro tem*

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CARCINOMA OF THE ENDOMETRIUM

continued from page 582

Conclusion

As a result of this study, we conclude that Cancer of the Endometrium is essentially a disease to be treated by surgery, panhysterectomy, but that the prognosis can be greatly improved through the use of Radium or X-ray as a preliminary to the surgery.

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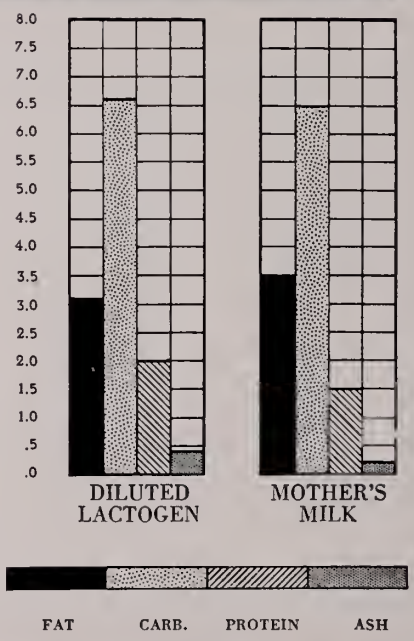
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Clinical Pediatrics, p. 156.

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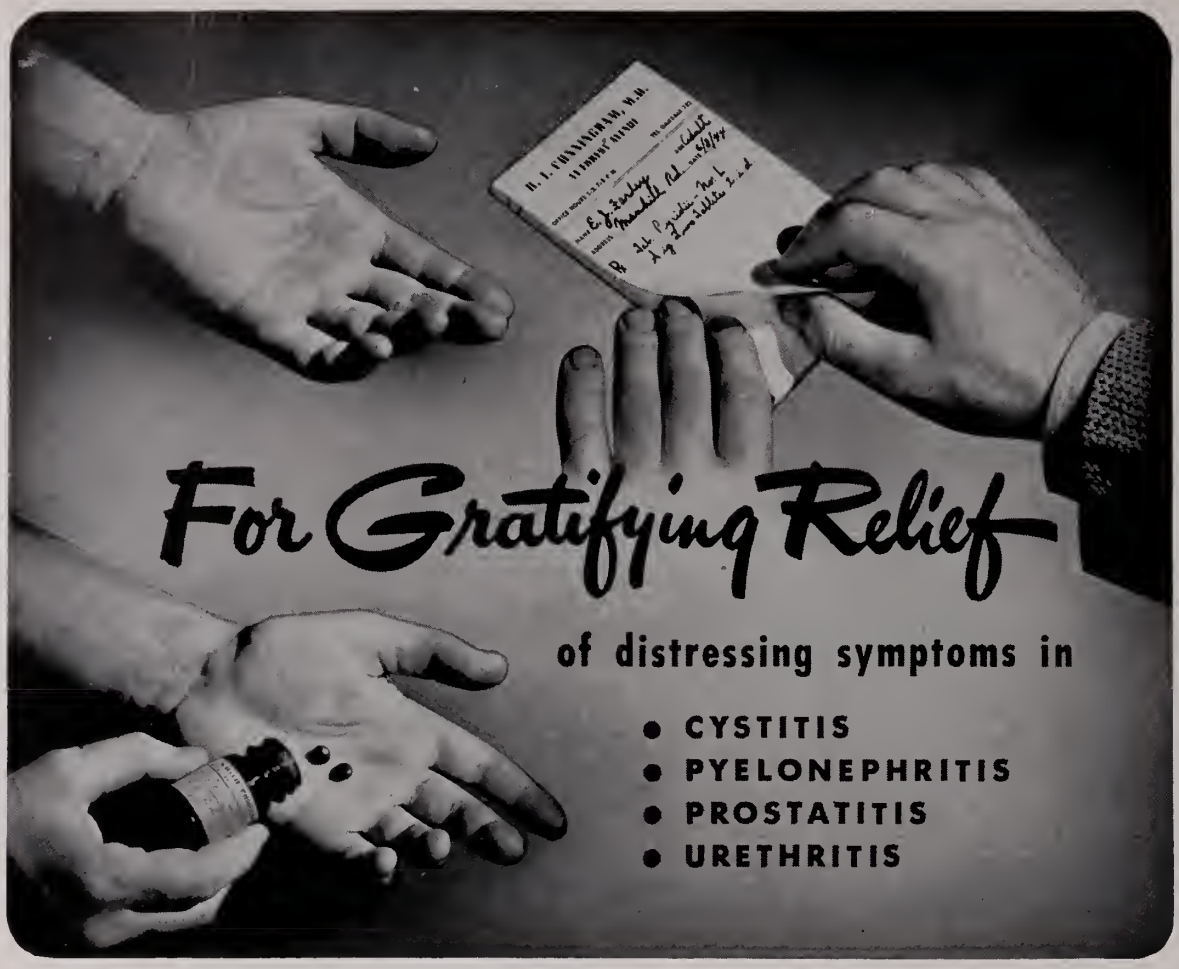
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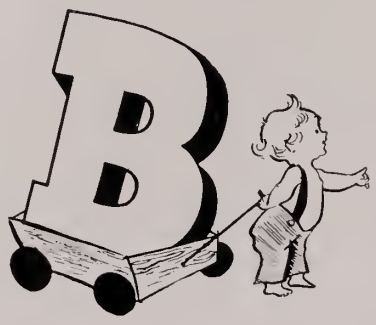
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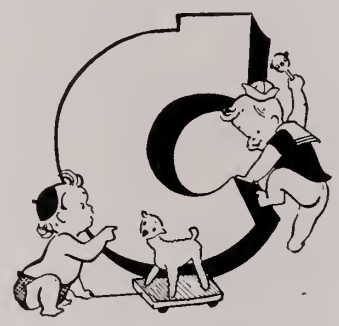
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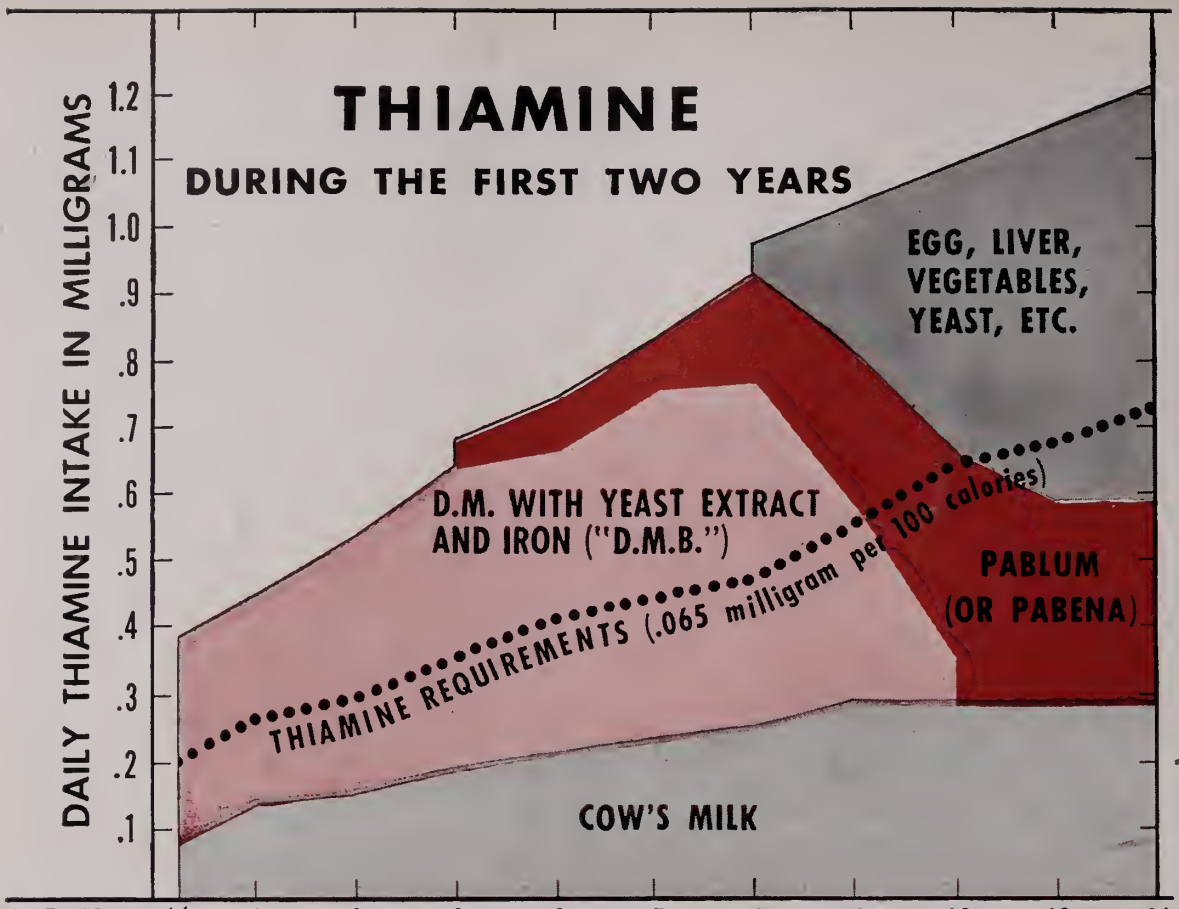
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Volume XXVII, No. 12 Contents Page 639

THE RHODE ISLAND MEDICAL SOCIETY
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVII DECEMBER, 1944 NO. 12

EYE SIGNS IN TWO HUNDRED DIABETICS*

HARRY C. MESSINGER, M.D.

The Author. *Harry C. Messinger, M.D., of Providence. Chief, Department of Ophthalmology, Rhode Island Hospital; former president of the New England Ophthalmologicol Society.*

SINCE the days of Naunyn it has been customary in speaking of eye troubles in diabetics to divide them into two groups: the young with rare or no eye-disorders but severe diabetes, and the old with mild diabetes and many eye-lesions.

This talk is based mainly on the observation of 200 people who came to me for relief of symptoms referred to the eyes. Twenty of the 200 did not know they were diabetics until it was discovered as a result of their visits to the office. The other one hundred and eighty were diabetics with the known duration of the disease from a few days to twenty-seven years in a woman aged fifty-four and twenty-two years in a man of twenty-seven. The average age of these cases was 61 years and 9 months. Eleven were 40 years or less. There were 49 men and 151 women.

The most frequent defects were in the retinae — retinal arteriosclerosis and allied conditions or complications such as hemorrhage and localized degenerations; retinal arteriosclerosis was present in the vast majority of cases, next most common was senile cataract — 86 cases. There were, however, 8 cases of eye-muscle paralysis, complete or incomplete, 9 cases of glaucoma, 3 were glaucoma simplex or chronic non-congestive glaucoma, five hemorrhagic glaucoma leading to the loss of 4 eyes and blindness in the fifth and one secondary glaucoma. There was one melanoma of the choroid.

One patient, a school-teacher had spent one week in a Hospital for introduction to a regimen of treatment for her diabetes. Her previous optical correction which had been working well until the fourth day in the hospital was O. U. +3.00 S = add +2.00 S for near. Refraction showed O. U. 20/20 without correction not improved, best near O. U. +3.00 Sph. One week later refraction O. U. +3.00 S = add for near +2.50 Sph. A change in refraction is common where the sugar-level in the blood falls rapidly, sometimes the change is in the opposite direction, more plus. At any rate any diabetic not under control may show varying results and reduction of plus spherical correction should be made cautiously, usually only after re-examination.

Six patients had lost in all seven legs, several had lost toes, three were definitely obese, there was one case of epilepsy and two of primary anemia. Three were proven syphilitics, two with four-plus Wasserman tests. A strikingly unusual body type was noted in three patients, a broad stout body with slender arms and legs, and in one case with such a body there was a tower skull. There were 2 known to have cancer of the breast and one of the uterus. One woman seemed rather proud of possessing an "upside down stomach." Only such non-ocular conditions as were apparent or brought out readily in history-taking were noted. Hypertension was present in many but I have no significant or valuable figures as to it.

Cataracts

I have listed as cataract only those with changes causing reduction of visual acuity to less that 20/30 with optical correction; in some cases where retinal pathology was enough to itself reduce visual acuity I relied on the extent and density of the opacities as viewed with the ophthalmoscope. Of 86 cases of cataract 5 eyes in 4 people had been operated on by others, 7 eyes in 5 people by me.

During the 2 years 25 eyes were operated on in 22 people. There were good results in 21 eyes. The poor results were due in two cases to extensive hemorrhagic retinitis, in one to intra-ocular infection following operation and in one to retinal detachment and hemorrhage into the vitreous. Two intra-ocular post operative infections were cured by sulphur drugs, with good visual acuity. In the case of the intra-ocular infection which did not get good sight, the infecting agent is not known, the eye is healed and not irritable but is practically

continued on next page

*Presented at the Third Medical Colloquium conducted by the Department of Medical Sciences, Brown University, on November 17, 1944.

sightless. One of the cases of hemorrhagic retinitis later developed hemorrhagic glaucoma, but the other eye in this case had a good functional result. No individual was so unfortunate as to get a poor result in both eyes. During the same period 112 cataract extractions on non-diabetics there were 6 failures, none due to infection. My experience confirms the generally-accepted view that the operation for cataract is more hazardous in diabetics and that complications such as infection, irido-cyclitis and hemorrhage are more common. It seems advantageous, especially in diabetics, to get the lens out in capsule if possible. In so doing there is less danger of post-operative irido-cyclitis; there is more apt to be hemorrhage into the anterior chamber but this is balanced by the absence of lens-remnants.

The diabetic therapy must often be altered during the hospital stay of the cataract patient. I have noticed especially in the case of the patient who has been getting along well at home with a daily dose of protamine-insulin the post-operative course is unpredictable. If he has been well-controlled at home, and we do not intend to admit him unless he has been so behaving, he is put on a 1500-1800 calorie diet and the urine is tested every 4 hours for sugar, at least for the first 24 hours; insulin and food are given as indicated by the urine test. Two cases of cataract in young individuals will be described later.

In every cataract case diabetic or not the urine is tested before operation and 24 hours after operation. One of our cases showed sugar after the operation although three examinations during the 3 months previous to admission had not shown it; during the 10 days of his hospital stay he required 20-30 units of insulin daily; three months after discharge he was released from observation by his Doctor, was leading an active life and earning a living on a diet with only minor restrictions and using no insulin. In the same room with this patient was another man (also one of the 22 operated on) who had been using 40 units of insulin each day at home. During his ten days in the hospital he required none. So that in diabetics although we have reason for more dread of complications and poor results, operations should be done if otherwise indicated. One patient, 84 years old, who had a glycosuria hard to control, got a good operative result, although vitreous was lost at operation and the wound was slow to heal.

Retinopathies

Visible signs of retinal arteriosclerosis were present in the majority of these cases. By these signs I refer to narrowing of the caliber of the arterial branches with or without irregularity, pallor and nicking of veins at arterio-veinous crossings. Because of the inability to see the fundi in many cataract cases and the masking of probable signs of arteriosclerosis in cases where there was much hemorrhage, retinal oedema or degeneration I do not think numbers are helpful. One is more impressed by the occasional patient over 60 with normal-looking vessels. One in particular, a physician over 70 with pink arteries of good caliber, clear lenses and only complaining of poor near vision, a refraction case. In terms of sugar a definite diabetic but one whom, so far, age has not withered. I cannot give any figures as to hypertension but hypertension is a bad and not uncommon complication. Again let me speak of a Doctor, 56 years of age: he showed as one of the early cases in the series, narrow pale tortuous arteries and nicking of veins, but no hemorrhages or white spots; he frequently showed sugar in the urine but claimed he kept in good order by dietary care. About a year later he phoned that his glasses should be changed. As I started to examine him I noted labored breathing; and before I looked I knew I would see signs of malignant hypertension, blurred elevated discs, twisted pale arteries, buried here and there by pale, greyish retinal tissue, splashy hemorrhages, some along branches of veins white radiating glistening lines of shiny spots about the macula. This was the most marked case of either hypertensive or arteriosclerotic retinitis out of six. He lived about 6 weeks.

There is a type of retinitis seen only in diabetics; this is characterized outstandingly by small round hemorrhages, appearing to be from smallest visible dots up to pin-head in size. Blotchy hemorrhages, roughly circular but flat, are often present but are not characteristic. Sometimes these hemorrhages are the only signs of trouble seen; widely scattered, they are more numerous in the zone two or three disc-diameters from the macula but in most cases there are also round, glistening white spots in the retinal background; some of these are in clumps and remind one in outline of the shadow of a bunch of grapes. This type of retinitis, called retinitis diabetica, was present in twenty of these cases; more than I had anticipated. There were besides these 20 cases, 6 cases of severe hemorrhagic retinitis with wide-spread, large sized, hemorrhages in the vessel layer; two cases of retinitis proliferans where the hemorrhages are pre-retinal, in the very deepest retinal layers just beneath the vitreous, blood escapes often into the vitreous. One of these cases, a woman 46 years old when first seen, I had watched for 7 years; during the first three years there were repeated hemorrhages into the vitreous first of one eye and then the other. After each marked hemorrhage this patient would reappear in my office, usually ascribing the relapse to cheating, indulging in a dish of ice-cream or a piece of candy. For a while

large clot-like masses would be seen in the vitreous finally clearing, then there developed small pale elevations or separations of the retina, which later shrank somewhat; new coils of small vein-like vessels appeared in and about the pale elevated areas. In *this* case expected increase in the frequency and severity of the hemorrhages and the little separations and vitreous strands with resulting blindness, did not develop. After about two years the hemorrhages occurred less frequently and for nearly 4 years non occurred. The visual acuity at the end of 6 years was about 20/60 in each eye; with a pair of rather strong glasses of short focus she was able to read. Once before I saw retinitis proliferans in a woman of 37 (not in this series) who was a diabetic and pregnant. In her case in less than a year there were present only a few strands in the vitreous and only 2 or three small retinal defects. This course is exceptional. Recurrences are the rule, and visual loss usually is serious. This was so in one other case, who also had lens changes. He became blind, lost a leg from gangrene, and died. The 47 year old woman who did much better as to vision, died of coronary occlusion.

There were six cases of retinitis circinata, where there was much hemorrhage and loss of retinal background with glistening crystal-like masses in the perimacular area, but invading more or less the macula. These cases had low visual acuity; one of them also had gangrene of the toes, losing 3 on one foot. Three patients had thrombosis of a branch of the retinal vein; one of these later had hemorrhagic glaucoma and lost an eye. One patient had a small hemorrhage at the macula; the vessels *appeared* normal.

In all these cases it was notable that the retinal hemorrhages were slow to disappear. Although I could not examine them frequently, in the case of the hemorrhages seen early in retinitis diabetica I would note the exact location of a small hemorrhage and weeks later find what looked like the same hemorrhage, with the *same* contour, the *same* deep red color and in the same spot. Larger hemorrhages perhaps were not so persistent in these characteristics but they were never any less in size or number and progressively affected visual acuity. And, still in respect to retinitis diabetica, in no case did I see a white spot replace a hemorrhage; for a long while it was supposed that these spots represented the sites of previous hemorrhages; my evidence (agreeing especially with Friedenwald of Baltimore) is against it. Hemorrhage into the vitreous, even large ones, on the other hand disappeared in a few weeks, but tended to recur. From these cases I am confirmed in the opinion that diabetes is a contributing factor in the frequency, severity and persistence of retinal hemorrhage.

Neurological and General

Eye-muscle palsies were as follows: 6th nerve, 6 cases.

Incomplete 3rd nerve, three, two with ptosis.

7th nerve 1 — peripheral type.

Complex, 1 — involving the distribution of more than 1 nerve.

Marked disturbance of accommodation, four cases.

The sixth nerve cases all did well; in the 3rd nerve cases, all three were apparently residuals of more severe involvement and changed not at all. One complex case was of several months' duration in a man arteriosclerotic, hypertensivee and diabetic.

I can offer little as to the neurological status of these cases or in fact of the 200 cases. Two of the 200 had corneal hypaesthesia on 1 side, one had hemi-anaesthesia of the face and anaesthesia of the fore-arms, wrists and fingers of both hands except in the ulnar distribution of one hand. There were 2 hemiplegias, two cases with mild mental disorders. In many cases atrophy of the interossei muscles of the hands was apparent, six volunteered the information that they had arthritis: one of these two had uveitis; we have not enough information about these cases and not enough cases to say much about the role of diabetes in intra-ocular disease involving the iris, choroid and ciliary body. Three patients had optic atrophy. 1 was a tabetic — 1 was a woman who had cataracts in both eyes and uveitis in both eyes, hemorrhagic retinitis 2 years after operation in the eye less affected by the uveitis and finally paper-white atrophy in this eye. This woman also lost a leg and at death had gangrene in the other leg. So far then we have seen impairment of vision due in the main to vascular disease and to degeneration of the crystalline lens, occurring in aging individuals; a group of 200 non-diabetics of the same average age would undoubtedly in general show the same sorts of trouble. The distinctly diabetic retinitis occurred only in the over-40 group but I *have* seen it in a patient 23 years old. We think we see as an effect of diabetes, more extensive and severe vascular lesions and more cataracts which seriously cut down visual acuity. It may be said that diabetics have all the eye-troubles that others have and do not do as well with them. Note that one patient had been operated on for cataract two years before diabetes was discovered and one other showed retinal arteriosclerosis four years before diabetes was diagnosed.

The Younger Diabetics

We spoke earlier of the cases 40 or less years of age. The opinion has been expressed that nowadays the young diabetics live longer and have more time in which to develop eye-disorders. This is

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reasonable but not altogether satisfactory. Let's take these few cases individually:

1. A girl 7 years of age referred because of inflammation in one eye; this proved to be interstitial keratitis. Investigation showed other evidence of congenital syphilis including 4-plus Wasserman test. For one year sugar has been well controlled. Recovery from the interstitial keratitis; second eye has not shown involvement.

2. Agnes H., 17 — Lens changes diffused about the center of the pupillary area and just beneath capsule (case lost sight of)

3. Ruth O., 19 — Known duration 3 years — eyes negative, has headaches especially in the morning. I understand that following a change in the routine of eating and dosage of insulin these headaches disappeared.

4. William B., 23 — Severe diabetes — duration four years. Ptosis, severe hemorrhagic retinitis. Visual acuity 20/50 or less.

5. Dorothy S., 24 — a known diabetic for four years, showed extensive hemorrhagic retinitis. In spite of expert handling of her diabetes from the time of her first visit she developed such haziness of the lenses that when she visited another Oculist he made a diagnosis of cataract. Later the lenses became almost entirely clear. In about 6 months Hemorrhagic Glaucoma developed in the right eye and a complete retinal separation in the left eye. The right eye was saved but is sightless, as is the left. She looks well, her diabetes through all this is well controlled, she earns her own living.

6. John C., 27 — known diabetic 22 years, except for refractive error his eyes are normal, uses about 60 units of insulin daily. Active life as an accountant.

7. Elizabeth Y., 30 — known 2 years — normal.

8. Richard W., 31 — known for 6 years, normal except for refractive error — uses 40 units daily.

9. Thos. E., 39 — uses lots of insulin, often 90 units in one day. Has blurred vision at times for 1 or two hours. Attributes it himself to over dose of insulin (more than he needed at the particular time); blood-vessels and lenses normal.

10. Joseph S., 37 — hemorrhage at macula in one eye. In the follow-up his urine showed sugar but in later examinations it was not present. At an internist's office — Urine negative, Blood sugar — at normal level when fasting but very poor in glucose-tolerance test.

11. Carmine P., — 40, a man, known for 6 months, extensive retinitis with low acuity of vision.

Thus in these 11 cases we have 3 individuals with severe hemorrhagic retinitis with bad results as to vision, 1 case of macula hemorrhage in a man of 37 with intermittent glycosuria and a poor record in the glucose-tolerance test.

The explanation has been given that in the course of years these young diabetics develop arteriosclerosis and therefore the retinitis. This explanation has been further elaborated by discussion of the effects of the relative amounts of fats and carbohydrates in the diet. None of these four cases with retinal hemorrhages had arterio-sclerosis by any signs such as narrowing and pallor of the visible retinal arterial branches or sclerosis of peripheral vessels nor does retinal arteriosclerosis show itself in my experience by hemorrhages before narrowing and pallor of the arterial stream is to be seen.

The two cases of lens changes represent the two types described in young diabetics. In one a girl of 17 we had only one observation; the visible changes were subcapsular. These may have remained unchanged or a full-blown cataract requiring removal of the lenses may have developed. Many of these cases have been reported and this lens change has been called a true diabetic cataract. Yet other cases have been reported in non-diabetics and I personally have had a case in a woman of 22, not a diabetic, where in one eye after 6 months from the first notice of visual loss, operation was necessary in one eye and in another 6 months it was indicated for the other eye. A better name is juvenile cataract in a diabetic or non-diabetic, as the case may be.

In the other case, where there was first noticed hemorrhagic retinitis, there appeared a diffuse bluish-gray haze throughout the lenses; this was not seen by me at its height but by another Oculist. I believe this is the only reversible cataractous change and it nearly disappeared in this case. I will not now go into a discussion of the reasoning about it.

I have gone over these younger cases in some detail because it seems to me that in general they have diabetes less complicated by other troubles such as hypertension and arteriosclerosis and that by consideration and study of them we may some day learn how to prevent or ameliorate the progress of retinal changes.

In our older patients, and in this series they outnumbered the younger about 16 to 1, we did find many eye-disorders which seriously affect sight. The diabetes was in most cases mild and there commonly were present hypertension, arteriosclerosis either or both, and in some senile changes; in others anemia or nutritional deficiencies. Except for the retinitis diabetica, a tendency to retinal hemorrhage and more rapid development of cataracts they do not differ much from others of the same age.

In the younger, we found 5 out of 11 with good eyes, except for refractive errors, one with a con-

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THE CONDITIONED REFLEX TREATMENT OF ALCOHOLISM*

JOSEPH THIMANN, M.D., of Boston

The Author. *Joseph Thimann, M.D., Medical Director, The Washingtonian Hospital, Boston, Massachusetts.*

ANYONE who has attempted to help an alcoholic to become an abstainer will admit that all the usual types of therapy have brought little success, if by "success" we understand no less than total abstinence. Any method of therapy claiming a high percentage of "cures" is easily reduced to what it really is if we inquire about the length of the period of total abstinence resulting from the treatment, how many records of patients can be produced, and what system of follow-up has been applied.

Neither hospitalization as such (whether by commitment or by voluntary admission to a luxurious sanitarium with very considerate, as well as considerable, "tapering off", or sudden withdrawal of alcohol, nor alcoholic farms, nor sedation, nor vitamins, nor gold injections, "drop treatment", benzedrine, nor even psychotherapy, including psychoanalysis, have brought more than meagre results.

Of course, I do not mean by this that hospitalization, alcoholic farms, benzedrine, and psychotherapy are not helpful adjuncts in the treatment of alcohol addiction. I use them and would not like to omit them. However, there is no doubt that their efficacy as eliminators of the craving for alcohol is rather small.

In fact, I suspect that the stepmotherly attitude toward the alcohol problem on the part of the medical profession has been to a great extent due to the discouraging results of the therapeutic methods mentioned above.

Under these circumstances, it was to the great merit of Lemere and Voegtlin of Seattle, Washington, that they inaugurated a treatment that approached the problem from a different angle, namely from the physiologic one.

Pavlov distinguishes two classes of reflexes:

(1) the *inborn* or *unconditioned* reflex, which is present in all members of a species, as, for instance, the extension of the leg on striking the patellar ligament, or the salivary flow as a response to the taste of food; and

(2) the *acquired* or *conditioned* reflex, which depends on the formation of new functional connections in the central nervous system and is therefore peculiar to the individual.

The first conditioned reflex experiments on dogs were conducted by Pavlov. He discovered that certain signal stimuli, like the sight and smell of food, are just as effective as the taste of food in evoking the salivary flow. This raised the question: Can any neutral stimulus, such as the ringing of an electric bell, be substituted for the natural stimulus in arousing reflex reaction? In putting this problem to test, the bell was sounded and kept ringing until after the food was presented. After about 30 trials, it was found that the sounding of the bell alone was sufficient to evoke the salivary flow. Thus a new reflex had been built up. At the same time, Pavlov found that:

(1) The *environment* must be controlled so that all stimuli more potent biologically than the ones under test are eliminated.

(2) Regarding the presentation of the stimulus: there are three possible ways of combining the neutral stimulus with the unconditioned stimulus. The bell may be sounded before presentation of food; simultaneously with presentation of food; or after the food is given. Only the first two methods result in a conditioned reflex. For the most efficient conditioning the new "neutral" or "conditioned" stimulus must not only *precede* the "natural" or "unconditioned" stimulus, but it must also *overlap* the other in point of time.

(3) The conditioned reflex will *fade* out gradually if the subject is exposed only to the conditioned stimulus for a long time without reinforcement by the combination of both the conditioned and unconditioned stimulus. In other words, if the ringing of the bell is used as a conditioned stimulus for a long period of time without the food (the unconditioned stimulus), the dog will finally stop secreting saliva when he hears it. Therefore, repeated reinforcements of the conditioned reflex are necessary.

Utilization of Conditioned-Reflex Laws

This new knowledge of the laws of the conditioned reflex was utilized for a therapy of alcohol addiction. The "neutral" or "conditioned"

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*Presented at the Evening Institute of The Research Council on Problems of Alcohol, at New York City, June 20, 1944.

stimulus of the ringing bell was replaced by alcoholic beverages, the "natural" or "unconditioned" stimulus of food by an emetic. It was to be expected that, after an adequate number of conditioning sessions, the presentation of alcoholic beverages alone would provoke the same response as the emetic, i. e., the sight, smell, taste, or even the thought of alcoholic beverages would cause nausea and emesis.

In practice, several difficulties had to be obviated. The first experiments taught that sedatives and depressants inhibit the reflex. Thus, not only the conditioning had to be postponed until the alcohol from the last spree was eliminated and the central nervous system had recovered from the depressant action of the alcohol, but it was also necessary to time the giving of alcoholic beverages in relation to the emetic so that the ingested alcohol would be vomited before it was absorbed and before the patient became partly intoxicated, i.e. narcotized, and thus unable to develop a reflex.

Another problem was the choice of the right kind of emetic. There is a very powerful emetic that has, however, two unfavorable after-effects: a euphoric and an hypnotic one. The result of the euphoric state is that the patient, instead of feeling sick after the treatment, feels "fine", which does not promote development of the reflex of abhorrence and nausea. The hypnotic after-effect causes a sound sleep for several hours, with subsequent amnesia, which also is not conducive to the desired results.

Finally, however, after years of research and experimentation, the right kind of emetic, with all the desired properties and none of the disturbing ones, was selected and a careful and skillful technique was devised.

Voegtlin and Lemere started this treatment more than eight years ago. In their last follow-up report on 1194 patients, they give the following results. Total abstinence was maintained in 74.8% of 644 patients treated within the last two years prior to the report; 52.5% of 291 patients treated two to four years prior to the report; and 51.5% of 259 patients treated four or more years prior to the report.

The conditioned reflex treatment as given at the Washingtonian Hospital and several general hospitals in or near Boston differs from the technique of Lemere and his associates in the formula of the injectable solution, in the dosage, and in some other technicalities.

More important than the differences in technique, however, is the fact that the establishment of a conditioned reflex is only one element in a tripartite plan of treatment, the other two elements of which are a part-time protective environment and supplemental psychotherapy, as described below.

The treatment is given in an initial series of four to eight daily sessions, followed by one-day reinforcements, at varying intervals, during the first year. These reinforcements are also the supportive framework for regular contact between the patient and the therapist. Some of my patients have requested that the reinforcements be extended over a second year in order that they may achieve a wider margin of safety. The happiness and gratification with the results of most of the "conditioned" patients is such that they are willing to return from a distance, such as Canada or Ohio, for the one-day reinforcement, notwithstanding the fact that the treatment is anything but a pleasure.

For the initial series of treatments, as well as the one-day reinforcements, hospitalization is indicated. As the treatment is given only to voluntary patients, any general hospital will serve the purpose.

Selection of Patients Important

The results of treatment depend largely on the selection of patients suited to this type of therapy. There are patients who are primarily promising and other patients in whom the chance of a successful outcome is poor. Some patients have only the *one* outstanding difficulty, the alcohol addiction. Otherwise they are relatively well adjusted, predominantly extrovert, have a successful working history, and good social and professional contacts. Such patients developed their addiction mainly by way of social drinking. In this type of patient, the elimination of the craving for alcohol by means of the conditioned reflex treatment, and sometimes even without supportive psychotherapy, is often sufficient for full rehabilitation.

In those cases where the addiction is *not* developed by way of social drinking, but is caused by an underlying neurosis of emotional instability, the elimination of the craving for liquor by means of the conditioned reflex treatment is only the elimination of a symptom. Psychotherapy of such patients, however, is made easier and has more chance of success if the patient has first undergone the conditioned reflex treatment. The psychotherapy is not then interrupted by drinking bouts and is facilitated by the patient's regained self-assurance. In *some* of these cases, too, the regained total abstinence, with all the emotional and economic assets involved, may be sufficient to help in improving the neurosis, even without psychotherapy. The masochistic traits with feelings of guilt, so common in neurotics, seemingly find gratification in the fact that the treatment is, as they say, "tough" and that they are atoning for their guilt. There is also a sense of heroic accomplishment as compensation for their inadequacies.

If there is a promising and an unpromising age group, patients between the fourth and fifth

decades have seemed to respond most favorably. In these patients their relative maturity, economic stability, and family responsibilities and attachments help to outweigh the alcohol addiction. Of course, the home situation can be an asset, or it can be a serious liability that will destroy the patient's chances. For instance, an aggressive, domineering wife or mother may be a very serious complicating factor that, under some circumstances, may prevent any rehabilitation. Also a wife who is what she calls a "social" drinker, and who sees no reason to give it up because she can "handle" her own drinking, may vitiate any attempts at changing her husband into an abstainer.

Physical contraindications to the treatment comprise in the main the cardio-vascular-renal syndrome, hepatic cirrhosis with or without esophageal varices, hernia (unless guarded), active peptic ulcer, or history of recent hematemesis and active psychosis.*

Protective Environment and Follow-Up Therapy

Of great help in the process of readjustment, especially for neurotic patients, is the part-time protective environment afforded by boarding at the hospital, while working full-time outside. The patients leave for their work after breakfast and return, when they are through work, straight back to the hospital. Also during weekends and holidays (the time when they have just received their pay-checks and are somehow less under control than on weekdays), the patients enjoy the protective environment of the hospital. Gradually their privileges are increased, the patient is more and more exposed to an unsupervised environment, the protection is reduced to weekends, and finally also this is abolished.

Quite an efficient factor in the follow-up therapy are the meetings of the Abstinence Club, or as they like to call it, the Conditioning Club, of our treated patients. These meetings give an opportunity for the men to meet together socially with other men with like problems and difficulties, and serve to re-enforce their regained self-respect and self-assurance which had been lacking during their decades of drinking. They readily contribute to the expenses of the administration of "their" club and one member celebrated his twentieth month of abstinence by donating to the Club the quite substantial fee for the treatment of a promising alcoholic. The club meetings afford also a chance for group therapy.

I have given the conditioned reflex treatment to 126 patients up to date. Of these, 53 had the treatment in 1942, 47 in 1943, and 26 in 1944. Of the 53 patients who took the conditioned reflex treatment in 1942, 45.2% are still abstinent. Of the 47 who had the treatment in 1943, 74.4% are still totally abstinent. Of the 26 patients who have undergone this treatment during 1944 to date, 23 or 88.4% are still abstinent. Thus, out of 126 patients who have taken the treatment since I started it in February 1942, 99 are still totally abstinent, or a percentage of 71.4. This figure includes 6 patients who tried to drink once, reacted with the expected nausea, returned voluntarily for re-treatment, and have remained abstinent since.

In conclusion, our experience with the conditioned reflex therapy over a period of 2½ years leads us to believe that this treatment, if applied correctly to selected patients and, if necessary, combined with psychotherapy and a part-time protective environment, represents the most promising treatment for alcohol addiction up to date.

*Quoted from "The Treatment of Alcoholism by Establishing a Conditioned Reflex" by Walter L. Voegtlin. Am. J. Med. Sc. *199*: 802-810, June, 1940.

By way of illustration of the problem the following Case Reports are submitted:

Habituation

No. 571 — F. A. H.
Age, 48.
Occupation — General Agent.
Education — High School, Preparatory School, College.
First admitted March 8, 1941, moderately intoxicated.

Alcoholic History — Patient had his first drink at the age of 23. From 1920 until 1931 the patient lived in the South. He did not drink during the summers at all. In the fall and winter he drank periodically. Prior to bout on admission, he was abstinent for 14 months, with the exception of two drinks. He then started drinking on week-ends, when he had to entertain professionally the officials of the railroad. He drank more than he should because of sociability and fellowship. After a few drinks "anything is funny and brighter, the sidewalks are wider, his voice seems stronger". The next morning, he felt horribly low and then took a drink. He got along with wife fairly well, but later admitted infidelity of his wife as a source of difficulty.

There were two subsequent admissions in 1941 and one in March 1942. Between April 6th and April 14th, 1942, the patient was given the conditioned reflex treatment, with seven reinforcements, the last one on March 10th, 1944. He is totally abstinent to date and active in the Conditioning Club.

Problem Drinking

No. 1362 — D. M.
Age, 42.
Occupation — Wood caulker in shipyard.

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This patient left school at the age of 14 and secured a job as an apprentice in a shipyard. After finishing his apprenticeship, he continued working at the shipyard until 1926, when he obtained a job, under Civil Service, in a Navy Yard as a "wood-caulker first class or shipwright second class". In 1932, during the depression, he was released from this job and secured employment in a Navy yard in another city. He stayed there until 1935. It was during this period of separation from his family and loneliness that he began to drink heavily. He returned to Boston and was re-employed at his old job for about four years. He continued drinking heavily, however, and was jailed for a period of ten days and later sent to Bridgewater State Farm for six weeks. Finally, in 1939, he lost his job and at the time of his first admission to the Washingtonian Hospital, in February, 1943, he was unemployed, had been arrested about fifty times and had been in Bridgewater six times When under the influence of alcohol, he was vicious and belligerent. In January 1943, he got into difficulties with the watchman of an industrial plant and was given a year's suspended sentence to Bridgewater. Because the patient was afraid of being sent to Bridgewater for life, and also because he feared he would "lose his mind", he sought help from the Court Probation Officer, who arranged for examination at the Peter Bent Brigham Hospital. He was examined there by a psychiatrist, who advised treatment at the Washingtonian Hospital. He was admitted on February 16th, 1943.

After two weeks' hospitalization, the patient returned to his work at the shipyard on working parole. In this way he was given the opportunity of earning to pay for the conditioned reflex treatment. The initial series of this treatment was given him between May 3rd and May 9th, 1943. The patient continued boarding at the hospital until December 16th, 1943. At this time, he remained away from the hospital for 15 days, but returned of his own accord. He did not drink during this interim and was quite proud of the fact that he had remained abstinent during the emotional period of the Christmas holidays. He continued on working parole until February 10th, 1944 and during this entire period of hospitalization received four reinforcements of the conditioning treatment. On March 4th he returned for his fifth reinforcement treatment.

Personality. The patient was a very insecure, unstable person, with a great many fears and anxieties. He was his mother's favorite and she favored him above the other children, always giving him the best and the most. His father, on the other hand, was deeply religious and a strict disciplinarian. His wife was older than he and assumed complete responsibility for managing the income, paying the bills, planning for the family, etc. There were four children and at the time of admission to the Washingtonian Hospital, the family were receiving assistance from public welfare.

The Social Worker was of great assistance in this case, in interpreting addictive drinking to the patient's wife, in assisting the family to plan the patient's earnings so that a number of back bills were paid up, and in arranging for a number of examinations for the patient in hospital out-patient clinics in order to relieve his anxiety in regard to many physical complaints.

The patient came in as an out-patient several times. He is not drinking and has no desire to drink at any time, and his wife and children are happy.

EYE SIGNS IN TWO HUNDRED DIABETICS

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dition due to syphilis, four with retinal pathology, especially retinal hemorrhages, one of these four also had lens changes and one case with normal retinae but with cataract. In these five it is reasonable to consider diabetes an important etiological factor.

So Naunyn's dictum in so far as it speaks of the young with severe diabetes and rare eye-disorders is not substantiated by these observations. As a generalization, taking in all diabetics, those without as well as those with eye-complaints, it is still good. Generalizations such as this are pleasing to the "ordered" mind but they explain very little and while expressing a part-truth are not satisfactory to the "inquiring" mind.

Previously I said "diabetics have all the eye-troubles that others have and do less well with them". This is another generality which sounds well but is not the whole truth. It fails to cover all the known facts. In 4 out of 11 young diabetics we had retinal hemorrhages lowering visual acuity, we had 20 cases with retinal hemorrhages of a type seen only in diabetics, we found more anterior chamber bleeding in diabetics after lens extraction; individual retinal hemorrhages in diabetics were slow to disappear and in general retinal hemorrhage did not regress and we saw more blood in the retinae of the older diabetics than in non-diabetics of the same age, whatever other changes were seen.

This tendency to bleed from the small vessels seems to me to point to the need of further study of the permeability of their walls. If arteriosclerosis only is the answer it should be shown by consideration of *all* the evidence and not be assumed because there is *some* evidence to support it.

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"UNSCRUPULOUS DOCTORS"

The Providence Journal has editorially expressed such grave concern regarding the possible sabotage of the state cash sickness fund by collusion of unscrupulous workers and unscrupulous doctors that we in turn have become a bit concerned about the Providence Journal.

We recognize the outstanding position this newspaper holds in our community, and we recognize the importance of bringing to the attention of the public generally the report of the prosecution of the four workers who defrauded the Sickness Fund. But the editorial comments on this report are as confusing and as misleading as some of the war news headlines which have won and lost twice as many battles as have been fought.

For example, the Providence Journal, in an editorial on November 15, stated in part as follows:

"However, we suggest that the punishment of individuals who collect benefits fraudulently, as essential as that is, is not in itself enough. Nobody can collect a claim against the Cash Sickness Fund without active cooperation of a physician, who must certify that the claimant is in fact ill and unable to work.

"It is entirely within the realm of reason that a person might be able to fool a doctor for a week or two into believing he was ill, but when the "illness" extends over a period of four weeks, as it did in one of the cases prosecuted, or of six weeks, as it did in another, the physician who certifies the case for benefit payments puts himself under suspicion either of being indifferent to his obligation to the State or of conniving with the claimant to defraud the State.

"Punishment of those who actually collect the money ought to be followed in every instance by an inquiry as to the circumstances under which the attending physician certified the claim, to the end that the possibility of collusion between unscrupulous workers and unscrupulous doctors may be prevented. The vast majority of those in the medical profession certainly are above becoming party to a fraud, but, as in every profession, there is a minority who are not. It is this minority that the Compensation Board must keep an eye on and move vigorously against whenever it finds evidence warranting it."

Now as for the facts in the case.

In its first year of operation the sickness fund had more than 33,500 claims filed against it and it paid out 3½ million dollars in benefits. We do not know how many more claims have been filed since last April or how much money has been paid

out. Out of all these claims four workers obtained a total of $217 by deceiving

1) their employer, for they worked and drew compensation at the same time.

2) the sickness fund administrators who failed to discover the fraud until long after its perpetration.

3) the certifying physician who could have recognized a reported ailment and agreed that the patient should not work although he might have done so without the physician knowing it; for, in accordance with the law which specifically states that the "act shall be construed liberally in aid of its declared purpose which declared purpose is to lighten the burden which now falls on the unemployed worker and his family," the physician could have certified to the disability honestly according to his training in the healing art and left the denial of continuance of benefits to the Board's paid staff of examining physicians.

The law stipulates that the protected employee may claim disability predicated on his physical or mental condition. It remained for the Board to make the rule that a physician must certify as to the disability. That certification, however excellent and honest, is open to challenge and denial by the Board. Thus we have the situation where worker A with the same disability as worker B, but physically different and requiring longer convalescence, is supposed to recover in the same period of time as B; otherwise he faces possible denial of cash benefits.

And who, other than the Providence Journal, blames the medical profession for the mechanical faults of a social insurance program upon which it was never consulted, and over which it has no jurisdiction? There are six professional groups licensed under the statutes and all are eligible to certify a claim for cash sickness benefits. The assumption that there was any collusion by any physician to perpetrate a fraud is a rash one; to imply that medical doctors abetted such a plan is adding insult to the injury.

The cash sickness act was drafted and enacted without any advice or counsel from the physicians of Rhode Island. In spite of the obvious faults and difficulties which have become apparent following the drafting of Board regulations that place the concept of sickness within the meaning of social insurance which is not identical with sickness as regulated by medical science, the medical doctors have cooperated to the best of their ability in the honest administration of their phase of the program. The act needs amendment and clarification to solve existing problems.

The Providence Journal, as the largest newspaper in the State, failed to inform the public fully and clearly regarding the sickness act during its 20-day passage through the Legislature so that everyone might understand the personal application of the law and not merely its social objective. If its present intention is to make up for that indifference, as well as that of employers and the public generally to the ramifications of this compensation measure, then there are far more vital tasks than the attempted shifting of the blame for the first frauds against the fund to the physicians of Rhode Island.

DR. J. HENRY MANNING

The man who attains distinction and honor in his chosen profession and who at the same time devotes unselfishly of his leisure hours to serve his fellow citizens in the administration of public policies and laws is indeed rare. Dr. J. Henry Manning was such a man.

A practising dentist in Providence since the turn of the century, Dr. Manning was one of the first in his profession to champion the cause of better dental legislation for the protection of the public. His efforts were instrumental in making the dental statutes of this state among the first in the country, and his colleagues honored him on two different occasions with the Presidency of the Rhode Island State Dental Society.

Not content to serve only his profession, Dr. Manning early developed a keen interest in public affairs, and this interest led him to seek public office. For twelve years he served with distinction as a member of the Providence City Council and in 1924 was the president of that body. He was once the choice of his party as candidate for Mayor of Providence, but he was defeated in this quest. In 1934 he was returned to public office as a state representative, a post he subsequently held until this year.

The profession he honored has indeed lost an outstanding member. The community he served has lost a valued public servant.

EXCHANGING VIEWS

Your Editor and Executive Secretary have been to the Annual Conference of State Secretaries and Editors at Chicago. One day and a half including an evening dinner and discussion were given to consideration of the most vital problems concerning the Medical Profession.

Dr. Herman L. Kretschmer, President, and Dr. Roger I. Lee, President Elect of the American Medical Association gave us informative and stimulating talks and Morris Fishbein, Editor of the Journal of the American Medical Association furnished us one of his keen, rapid fire and pertinent discussions. There were representatives there from Washington to Florida and Massachusetts to Southern California all giving of their hoarded time to consider some of our many vexing questions.

And as usual there were small side meetings of groups where the men "took their hair down" and talked more frankly and intimately of their pet topics than could be expected in the formal meetings.

It is hardly worth while to summarize the deliberations. Of course nothing much was solved. Rarely do our social troubles reach a quick and easy solution like this. But a large group traveled far and applied themselves diligently to these tasks.

It is a pleasure to pay tribute to our parent organization and the officers who made possible and arranged this opportunity for us to air and compare our views. Dr. West is not only highly efficient but delightfully gracious as the guiding spirit.

In the opinion of one person at least the ideals of the Medical Profession and the way they have been carried out are outstanding among human achievements. But the public led on by agitators have decided largely to ignore the manifest abuses of the law, business, advertising, etc. which make our ways seem Utopian and they are going to put lace on all our lingerie before they tackle the really dirty clothes.

All we can do is recognize this and continue to confer that we may seek out ways to direct the sewing circle ourselves. That is the one distinct impression brought home from Chicago.

A STATE CANCER COMMISSION

In 1941 the Rhode Island General Assembly placed on the statutes the act which make obligatory that any physician knowing or having reason to know that a patient treated or visited by him has cancer in any of its forms report the date to the State Health Department. A year later the Assembly passed legislation which authorized the State Health Department to set standards for cancer units in general hospitals, to conduct cancer control educational programs and to provide a plan to care for needy cancer patients. To carry out the latter program the sum of $15,000 was appropriated, and this grant has been continued each year since.

The war, demanding as it has so many doctors, undoubtedly has prevented in some measure the development of a Cancer Division within the state health department. However, if the data accumulating as the result of the 1941 legislation is to provide its intended purpose — the compilation of vital statistics relative to the incidence of the disease in all its peculiarities — and if the wishes expressed by the Assembly when it appropriated public money two years ago are to be fulfilled, there is need for some advisory group to co-ordinate the cancer control program in Rhode Island.

The recommendation that has been advanced by the Cancer Committee of the Rhode Island Medical Society that there be a State Cancer Commission, created and established by legislative action, to serve in an advisory capacity to the director of health to formulate what will be long range plans in cancer care, treatment, and education, is worthy of adoption. Similar commissions have been instrumental in the operation of successful programs in Maine, New Hampshire, Vermont and Connecticut.

RED CROSS AUTHORIZATIONS

PROVIDENCE CHAPTER

THE AMERICAN RED CROSS

HOME SERVICE DEPARTMENT

228 WEYBOSSET STREET, PROVIDENCE 3

November 15, 1944

Mr. John Farrell
Rhode Island Medical Society
Francis St.
Providence, R. I.

Dear Mr. Farrell:

Due to the fact that the Red Cross Home Service has met with some difficulty in the plan for authorization of doctor's calls to service-connected families, any call placed by a Red Cross worker in behalf of a family with the doctor's exchange automatically authorizes the payment of the doctor's visit to the family and the doctor will be reimbursed by Red Cross as per our agreement of $3.00 for a home visit.

If a doctor is called to visit a family and is told that Red Cross will pay for the call, we request that the doctor telephone to DEXTER 2155 and find out whether or not the call has been authorized.

We find that some abuse of the fact that Red Cross will authorize a visit by a doctor has occurred and that some families which Red Cross does not know has stated that Red Cross will pay the bill. This agreement is for the protection of the medical profession as well as Red Cross. Red Cross is on 24 hour a day service and we will make every effort to keep a listing of the calls which have been authorized so that there will be no delay in receiving an answer to a doctor's request.

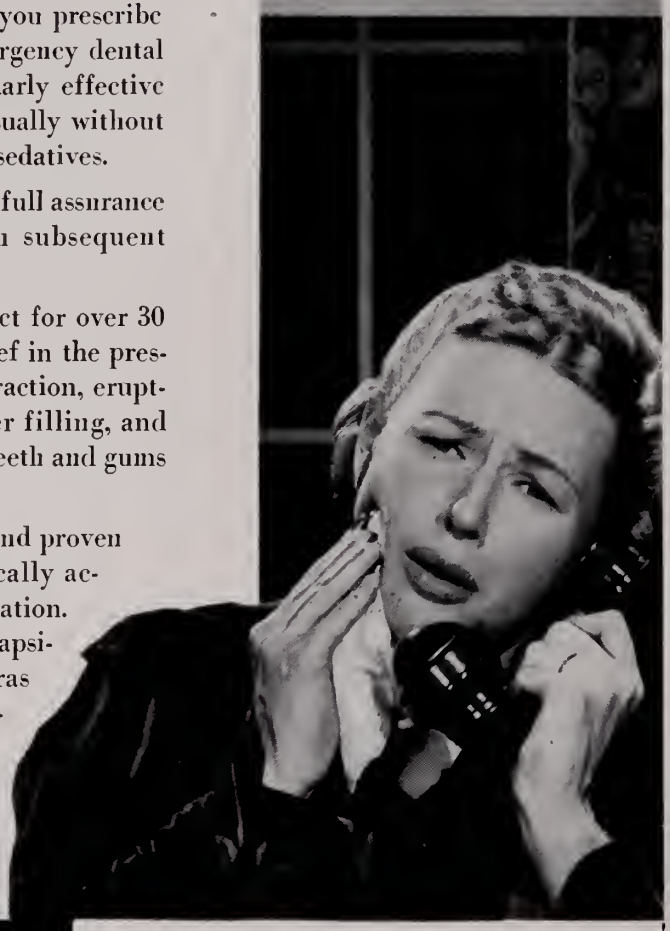
At this time let me once more express our appreciation in behalf of the servicemen, their families and the Military for the splendid cooperation which the medical profession in Rhode Island gives to us in verifying the need for emergency furloughs and for extensions. We recognize how great an obligation this is to the many busy doctors in this city. As you know we make these verifications with the medical profession at the request of the Military Officers and Naval Officers and it is only through the doctor's diagnosis, prognosis and recommendation that a furlough is granted.

We hope that the above agreement will meet with your approval.

Very sincerely yours,
Dorothy M. Calef
(Mrs.) Dorothy M. Calef
Director of Home Service

DMC:GG

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HELPFUL HINTS IN NITROUS OXIDE-OXYGEN ADMINISTRATION FOR DENTAL SURGERY*

HARRY M. SELDIN, D.D.S., F.I.C.D., F.I.C.A.

The Author. *Harry M. Seldin, D.D.S., of New York City. Fellow, International College of Dentists; Fellow, International College of Anesthetists.*

"A NEW era in tooth-pulling" was the exclamation made by Horace S. Wells when he regained consciousness after having his own tooth extracted under nitrous oxide-oxygen anesthesia on December 11, 1844, just 100 years ago to-day.

Wells was a practicing dentist in Hartford, Connecticut, a serious student, constantly on the alert for some means of combating the pain incident to the extraction of teeth. He attended a lecture and demonstration at Hartford given by Gardener Colton, a chemist, on the effects of nitrous oxide. Wells noticed that persons under the influence of "laughing gas" experienced no pain. He then asked to become a subject himself and requested to have one of his own teeth extracted while under the influence of the gas. Thus the dawn of modern anesthesia appeared on the horizon.

One hundred years have passed and we have made remarkable strides. Yet, have we gone far enough? Nitrous oxide-oxygen is still the general anesthetic of choice in oral surgery and yet 95% of the dental profession are not sufficiently qualified in the art of its administration.

Those who employ nitrous oxide-oxygen extensively, fully realize its many advantages when administered intelligently and efficiently. Yet, in spite of accepted facts, many members of the dental and medical profession continue to harp on the dangers and limitations of nitrous oxide-oxygen anesthesia and of its supposed contra-indications. To the anesthetist thoroughly trained in administration of nitrous oxide-oxygen for dental and oral surgery, there is only one contra-indication—"inexperience." Any anesthetic agent is only as safe as the qualifications of the anesthetist. After one hundred years, it still remains the safest and best general anesthetic for dental and oral surgery in the hands of those who have mastered it.

Though the dental anesthetist is not expected to be an internist, he should have an understanding of the heart and what he may expect of it, in order that he may anticipate trouble; know how to prevent it and be able to cope with it, should it occur. Carrying the patient in deep narcosis for a prolonged period with any anesthetic agent may cause irrepairable damage to the brain cells. Nitrous oxide produces anesthesia primarily by limiting the oxygen supply to the brain. There is consequently some mild form of oxygen deprivation or anoxemia present in all nitrous oxygen administration. The anesthetist should bear in mind the fact that the displacement of oxygen from the body, by the nitrous oxide, becomes more rapid during deep narcosis, and the resulting anoxemia can become dangerous by its depressant action on the gray matter.

Marked anoxemia depresses the vasomotor control of the cerebral vascular system. A stagnation of the blood in the brain is thus produced with the resulting accumulation of carbon dioxide and further reduction of oxygen to the brain cells. As the cordical cells are sensitive to oxygen want, they undergo structural changes which may result in irrepairable damage to the brain cells. The respiratory and cardiac centers may be so depressed as to cause death.

The principle factor in gas oxygen anesthesia is to always keep the patient in light anesthesia, thus minimizing the oxygen want, so that no ill effect is produced upon the human body. Post anesthetic numbness of the fingers or feet, spasmodic contraction of extremities, clenching of thumb and fingers, persistent severe headache, or dizziness, severe crying spells, are symptoms of anoxic anoxemia. When these occur upon awakening from nitrous oxide-oxygen, the patient has been carried too deep.

In any nitrous oxide-oxygen administration, some disturbing and puzzling symptoms may become evident and it is imperative that the anesthetist should be able to interpret them and thus correct them. There is an old maxim in gas oxygen anesthesia that will always hold true "If in doubt as to any symptom, administer oxygen."

A pulse slower than normal signifies deep narcosis. Correction: Gradually increase the oxygen percentage.

Cyanasis, in the normal patient indicates deep narcosis. Correction: Several spurts of pure oxygen.

Ashy-gray color of skin always indicates deep narcosis. Correction: Administer pure oxygen.

continued on page 657

*An address delivered at the Dr. Horace Wells' Centennial Dinner, at Providence, December 11, 1944.

A TROUBLE-MAKER?



Yes, a loose, ill-fitting denture* often can be a trouble-maker. It can cause embarrassment, induce nervousness, and contribute to poor digestion as a result of insufficient mastication.

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**Loose, ill-fitting dentures are usually the result of changed bone and tissue formation. In severe cases the patient should, of course, see his dentist.*

DR. WERNET'S POWDER

Holds dentures firmly and comfortably in place



NITROUS OXIDE-OXYGEN ADMINISTRATION FOR DENTAL SURGERY

continued from page 655

Frequent swallowing, retching, and a pale green color in the skin of the face are all warning symptoms of nausea and vomiting. Correction: Several breaths of oxygen.

Perspiration, with forehead warm, usually denotes excessive CO^2 and rebreathing. Correction: Reduce degree of rebreathing or concentration of CO^2.

Perspiration, with forehead cold, indicates deep narcosis and approach of shock. Correction: Administer pure oxygen.

Clonic spasms of body muscles may accompany deep anesthesia. Correction: Increase oxygen percentage.

Tetanic spasms of body muscles indicate deep narcosis. Correction: Administer several spurts of pure oxygen under pressure.

Purposeful muscular movements indicate that the patient is too light. Correction: Increase pressure and administer pure nitrous oxide.

Purposeless muscular movements indicate that the patient is too deep. Correction: Increase oxygen percentage.

Opisthotonos (bridging or arching) may be a sign of deep narcosis or of excitement. Compare with other symptoms. Correction: Administer one or two spurts of pure oxygen under pressure if deep, pure nitrous oxide if in the excitement stage.

If the pupils are large and react actively to light, and the lid reflex is present, the patient is too light. Correction: Reduce the oxygen percentage.

If the pupils are large and do not react actively to light and the lid reflex is absent, the patient is too deep. Correction: Increase oxygen percentage or force pure oxygen.

The manifestation of nystagmus (vertical or horizontal oscillation of the eye ball) takes place in the light phase of anesthesia. Correction: Reduce the oxygen percentage. Fixed eyeballs, staring, and the oxygen percentage. Fixed eyeballs, staring and without reflexes occur in deep narcosis. Correction: Administer pure oxygen under pressure.

Sighing is an index of good anesthesia when it occurs at infrequent intervals. Otherwise, it is evidence of oxygen want or a superabundance of carbon dioxide. Correction: Addition of oxygen or reduction of rebreathing.

Crowing occurs in deep narcosis as a result of spasm of the laryngeal muscles. Correction: Increase oxygen percentage, or give spurt of pure oxygen.

Prolonged inspirations mean light anesthesia. Correction: Decrease oxygen percentage.

Breath-holding, provided that the reflexes are active, may be taken to signify light anesthesia. Correction: Reduce oxygen percentage.

Prolonged jerky expirations, also known as stertorous breathing is a phenomenon of deep narcosis. Correction: Increase oxygen percentage.

Pause between breaths indicates that the patient is deep. Correction: Increase oxygen percentage.

Cessation of respiration, together with the abolition of all reflexes, represents extreme depression of the respiratory center in the medulla by anoxemia. Correction: Establish open airway; force pure oxygen under pressure; and apply resuccitative measures.

On this, the one hundredth anniversary of the discovery of nitrous-oxide as an anesthetic for dental surgery, let us all resolve to learn the art and science of anesthesia. The relief of pain in the dental chair should be one of our main objectives. Good dentistry and painless dentistry are synonymous, and both can be mastered.

REFERENCE

"Practical Anesthesia for Dental and Oral Surgery." ... Seldin "Lea and Febiger." 1942.

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The gift of beauty—forever. There is nothing that so typifies the spirit of giving as does the diamond. There is nothing that can continue so surely to maintain its beauty, its value, its sentiment.

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Therapy in Nutritive Failure

IN MANY, if not most disease states, the therapy of nutritive failure is important in hastening convalescence and restoring the patient to a state of health.

The four essentials for therapy in nutritive failure include . . .

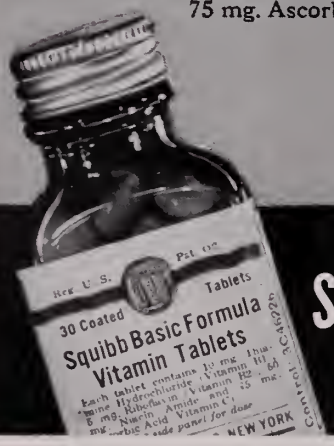
1. **DIET:** 4,000 calories, 150 gram protein, rich in vitamins and minerals.
2. **BASIC THERAPY:** Thiamine, riboflavin, niacinamide, ascorbic acid, orally.
3. **ADDITIONAL MEDICATION:** Synthetic vitamins as indicated orally or parenterally.
4. **NATURAL B COMPLEX:** Brewers' Yeast or extract, or rice bran extract, and/or liver extract orally or parenterally.

The Squibb Laboratories provide three of the four essentials for such therapy. They provide BASIC FORMULA VITAMIN TABLETS for intensive BASIC THERAPY—note their content:

10 mg. Thiamine Hydrochloride
50 mg. Niacinamide
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This is the basic formula used by Drs. N. Jolliffe and T. D. Spies and described by the latter in his paper on Nutritional Rehabilitation of 100 American workers for Industry.

Squibb also provides the synthetic vitamins indicated for *additional medication* as well as the *natural B Complex* factors—the fourth essential therapy of nutritive failure.



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ARTHUR H. RUGGLES, M.D., *Editor*

WAR-TIME VOLUNTEERS IN HOSPITALS

All voluntary hospitals have depended on the service of friends from their very beginning. We seldom remember that the Boards of Trustees and members of the Visiting Staffs give their time, without salary, and thereby constitute essential volunteer groups without which hospitals could not operate. During normal years, many people have been interested in aiding in the care of the sick but never to the extent that is now needed. There are many ways in which this may be done.

Male Attendants

Male attendants are just not obtainable. The young men are in service and industry has taken nearly all the others who are employable. However, business and professional men, who have the proper spirit, have come to the rescue. After a well organized course of instruction in the ways of hospitals and in the duties of male attendants, they work either morning or evening hours in operating rooms, male wards or the accident rooms. And they do it well.

The American Red Cross has recruited and trained four groups for service to civilian hospitals, viz; Nurses Aides, Gray Ladies, Dietitians Aides and the Motor Corps.

Nurses Aides

The need for these arises from the fact that the Armed Forces have taken so many graduate nurses that there are not enough to staff the hospitals. The number of student nurses has increased, stimulated somewhat by the formation of the Nurses' cadet Corps, but the number must be limited by the instructors and class-room space available. Part of the student nurses time must be allocated to the educational phase of her training so her service to patients must be definitely limited. The American Red Cross recruits candidates, employs a graduate nurse as instructor and uses the wards of the hospitals for the practical part of the training. The classes occupy 80 hours, and the Nurses Aides agree to work 150 hours a year.

Gray Ladies

The Gray Ladies are also organized by the Red Cross, having a training course. They have duties as follows:

Serve at Information Desk, or on the wards in secretarial capacity to the Head Nurse, upon request.

Take care of flowers.

Accompany patients to X-Ray or Operating Room.

Bring papers or magazines of interest to patients if they desire.

Do shopping for patients.

Act as messenger for Head Nurse.

Make drinks — force fluids — limit fluids.

Feed patients at meal times.

Write letters for patients, or read to them if desired.

Assist in discharging patients.

continued on next page

CHAPIN SEEKS PSYCHOPATHIC AID

The following appeal, received from Dr. William Hindle, superintendent of the Charles V. Chapin Hospital, warrants the attention of the Doctors of the state:

"Owing to the recent unlooked-for loss of a large share of the essential personnel of the psychopathic department of the Charles V. Chapin Hospital by recruitment to the armed services, the administration is making an appeal to the doctors of the state and city to help in the relief of a desperate situation. The administration is painfully aware of the need of hospitalization for the study of mental patients by temporary observation. It is, however, not fair, under the present circumstances, to admit to the wards patients beyond the ability of the personnel to care for them adequately. The standard level of service must be reckoned with.

"It is hoped, by lowering the intake of patients temporarily and by the institution of all available means to augment the manpower, our objective will be attained at an early date. A helping hand now will be greatly appreciated by the administration. Your cooperation and patience is fervently solicited in order to meet the present bad situation. After a brief respite, during which an adequate nursing personnel may be built up, the hospital will again admit the mentally sick to the full capacity of the institution."

Act as hostesses during visiting hours, conducting visitors to patients, etc.

Answer call light and summon Nurse or Nurses' Aide, if the service needed involves one of their duties.

Assist in making supplies and counting linens.

On holidays, such as Christmas, Halloween, Fourth of July, etc., assist in decorating Ward if the Hospital so desires.

Dietitians Aides

The dietary Department must supply hot, palatable food at the bedside in many different locations remote from the point of preparation at approximately the same time. When to that is added the various limited and special diets which must be served besides the regular full diet, the magnitude of the problem created by diminished personnel is apparent. The Red Cross has helped this situation by training Dietitians Aides.

Motor Corps

The drivers of ambulances and beach-wagons have been trained and certified by the American Red Cross and they bring patients to clinics at hospitals and return them to their homes, particularly those who are elderly and younger people who find it difficult to get about.

There are other departments in the hospital in which volunteers have been found very useful.

Accounting Department

The problem of patients' bills alone constitutes a large volume of business particularly in view of the fact there are variable basic rates, with charges from various service departments which have to be sent to the Accounting Department and these bills may be paid by the patient in full or in part, by the Blue Cross, by the employer under the Workmen's Compensation Act, by insurance companies under health policies, or by the Directors of Public Welfare. This same department must keep an account of all bills for supplies and services furnished by outside agencies and must keep an account of and pay all wages. Volunteers have helped here in the evening hours.

Blood Bank

The problem of taking blood, typing it and processing it can only by done by people who are technically trained for the job. However, volunteers are useful here in recording and issuing both blood and plasma on requisition.

Central Supply Room

Preparation of various kinds of sets for intravenous medication, spinal punctures, paracentesis sets of various sorts may well be made up by volunteers working under the supervision of graduate nurses.

Housekeeping Department

Issuing, repairing and laundering of the large amount of dry goods which hospitals use, cleaning of corridors and the running of elevators are duties which can be performed by volunteers who bring to the job knowledge of those techniques.

Information Desk

Reception of visitors and accurate maintenance of the register of the patients, the handling of mail and gifts for patients so that they get to the proper persons are the chief duties at the Information Desk. Volunteer help is indeed welcome here.

Laboratory

Most of the work done in the pathologic laboratory pre-supposes previous training as a necessary requisite for proper work. Some people who have been trained in these techniques and are not doing this kind of work now, have been able to volunteer a little time to this department and some groups have been trained to do some of the procedures which are not too involved.

Nursing School Office

The large amount of paper work necessary as part of the work of the Nursing School Office, both to record the educational progress of the

continued on page 687



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[1] Kling, D. H., Sashin, D., and Spanbock, J.: J. Lab. & Clin. Med. 24:1241, 1939.

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Plus all other factors naturally occurring in yeast concentrate. Noviplex is supplied in bottles of 100, 500 and 1000 capsules.

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SEMCO

REPORT OF A CASE OF STAPHYLOCCUS BACTEREMIA TREATED WITH SULPHADIAZINE AND PENICILLIN

JOHN F. KENNEY, M.D.

The Author. *John F. Kenney, M.D., F.A.C.P., Chief of the Medical Division and Director of Laboratory, The Memorial Hospital, Pawtucket, Rhode Island.*

My reason for presenting this case is first to contrast present day treatment in these bacterial infections — that is, the results obtained — compared with those expected several years ago. Secondly, we note the fact that this patient's only sister died of a subacute bacteriological endocarditis four years ago. This we definitely found by autopsy.

The patient is a twenty year old white American female, admitted on June 23, 1944.

Family History: Father and mother living and well. 1 sister died of subacute bacterial endocarditis.

Past History: Always well except for an occasional cold. Had a fall in office where she works and was out of work several weeks with a so-called sacro-iliac.

Menstrual History of periods being delayed one month.

Present Illness: About three days before entrance, patient was treated for what her mother called the grippe. Given empirin and went to work. Taken home that day with temperature 104. Physician called who sent her to hospital as she had become delirious and unmanageable at home. Required restraint on admission to hospital. Temperature on hospital admission 105.6.

Physical Examination: Well developed and nourished white female in bed. Back and neck rigid.

Eyes — pupils somewhat dilated. Impossible to do a satisfactory eyeground examination.

Teeth, mouth, throat and ears negative.

Chest — heart and lungs are negative.

Abdomen — soft. Liver and spleen not felt. No masses.

Reflexes difficult to evaluate as on touching the patient in any part of the body she would cry and scream and thrash around the bed.

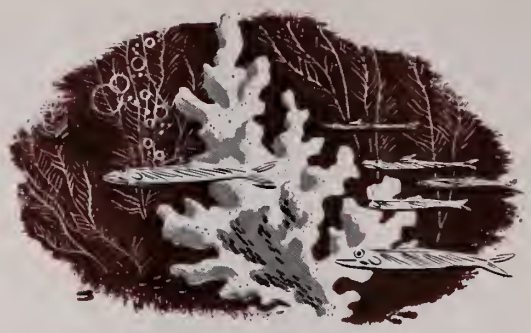
Diagnosis of a meningeal infection made and a spinal puncture and blood culture obtained. Spinal fluid faintly cloudy. No organisms obtained on smear. Blood: 5,180,000 R.B.C., 8,800 W.B.C., Hgb. 14.3; Polys. 84%. Smear and culture from nose and throat negative. Urine: yellow, acid, 1.014; sugar negative, Albumin; sediment: 1 epi. cells; 1 leucocytes.

Patient placed on routine treatment with clyses and large doses of sulphadiazine. Temperature dropped to 103 in 48 hours and to 100.2 in the next 24 hours. The laboratory reported on culture both from spinal fluid and blood culture. A staphylococcus aureus hemolyticus. On the fourth day patient had a chill and temperature started to rise to 103.4. The sulfa level obtained on June 24th was 18.6; June 25th was 29; June 26th was 24; June 27th was 14; June 28th was 10.

Blood count on June 29, 1944:
R.B.C. 3,940,000; W.B.C. 16,400; polys. 88%
Blood count on July 3, 1944:
R.B.C. 4,100,000; W.B.C. 14,800.
Blood count on July 19, 1944:
R.B.C. 3,420,000; W.B.C. 15,100; polys. 75%.

On the fifth day with another chill and 103.4 temperature, penicillin started intravenously and followed by intramuscular injections until temperature became normal for one week. Following blood culture reports, source of infection presented a problem. Slight vaginal discharge and delayed period considered as slight bloody discharge started and continued vaginally for several days. Smears and A.Z. test proved negative. History finally obtained from mother that about ten days previous to entrance, patient had a slight infection on toe which four to five days of soaking in Lysol had cleared up. No evidence found on examination of this toe at present time. Repeated examinations of chest revealed nothing unusual until heart examined on the tenth day when a slight systolic murmur was heard at apex which sound subsequently increased each day and could be heard all over precordium. P 2 somewhat accentuated on the twelfth day of illness. Embolic phenomena were observed on several fingers of both hands and several toes and both heels. Cultures and smears obtained from these areas revealed staphylococcus aureus hemolyticus. The temperature became normal on July 13th, the 21st day of illness. Averaging between 99.4 to 102.5 and then remained normal until July 29th, the 37th day of illness. A total of 690 grains of sulphadiazine was

continued on page 665



50% Better Absorption

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Moreover, Fergon (ferrous gluconate Stearns) is so free from irritation that it can be administered even on an empty stomach—the ideal condition for maximal utilization.

**Reznikoff, P., and Goebel, W. V.:* The Use of Ferrous Gluconate in the Treatment of Hypochromic Anemia. *J. Clin. Invest. 16:547, 1937.*

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RUPTURE OF LUMBAR INTERVERTEBRAL DISKS*

CHARLES S. KUBIK, M.D.

The Author. *Charles S. Kubik, M.D., of Boston. Associate Neurologist, Massachusetts General Hospital; Instructor in Neurology and Neuro-pathology, Harvard Medical School.*

THE onset of symptoms in most cases is related to an injury, such as lifting, a wrench, or a fall on the buttocks. Repeated attacks are the rule. In the earlier attacks pain is likely to be limited to the lower back. Eventually sciatica develops and is the outstanding symptom in practically all cases that come to operation. Flattening of the lumbar spine, limitation of forward bending and limitation of straight-leg raising occur in nearly every case and list of the lumbar spine is only a little less common. Paresthesia is a frequent symptom. Neurological examination is often negative. The angle jerk is diminished or absent in 50% of the cases, usually with rupture of the 5th disk, though occasionally with rupture of the 4th disk. The knee jerk is rarely affected. In a fair number of cases there is sensory impairment. Distribution of pain, paresthesia and/or sensory impairment is of considerable localizing value, though not always dependable; the top and inner side of the foot and the big toe are commonly affected in rupture of the 4th disk and the outer side of the foot and the little toe in rupture of the 5th disk. Weakness of dorsiflexion of the foot occurs occasionally. as a rule the total protein of the spinal fluid is slightly or moderately elevated, not often above 85 mgs. per 100 cc., though in some cases, it is normal. Narrowing of the 4th lumbar intervertebral space, shown by X-ray, is suggestive but not diagnostic of ruptured disk. Narrowing of the 5th intervertebral space is of little significance because of the marked normal variations in its size. A normal intervertebral space does not rule out ruptured disk.

Myelography with lipiodol or pantopaque is used at the M.G.H. to confirm diagnosis and localization. The oil is removed through the lumbar puncture needle immediately after the examination. Simple diagnostic lumbar puncture is generally omitted.

*An Abstract of the presentation of the Subject at the Second Medical Colloquium conducted by the Department of Medical Sciences, Brown University, on October 20, 1944.

Operation should be reserved for those cases with intractable pain which does not respond to conservative measures and cases with frequently recurring pain. In the latter group, since recurrence is almost certain, time spent on conservative treatment is almost sure to be wasted.

CASE REPORT

continued from page 663

used in the first four days until penicillin was started and a total of 2,250,000 units of penicillin was used throughout the remainder of the illness until discontinued.

NOTE: Patient was last examined on October 3, 1944, feeling well and back at work. Still presents slight blowing systolic murmur. The possibility of a vegetation condition on the heart valves, a so-called subacute condition in remission, has to be kept in mind.

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Paredrine-Sulfathiazole

How It Shortens the Course of Infection and Helps Avert Sequelae to Colds

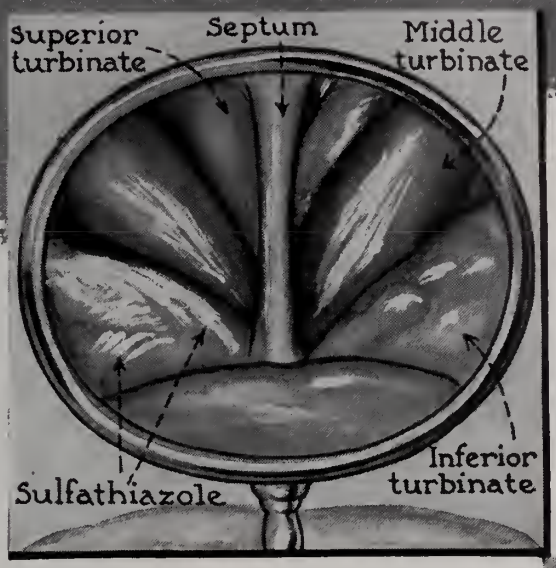
THESE drawings—from photographs presented as a scientific exhibit at the 1944 Meeting of the American Academy of Ophthalmology and Otolaryngology—demonstrate why Paredrine-Sulfathiazole Suspension is so strikingly effective in nasal and sinus infections. The choanae of patient T. D.—with subacute pansinusitis—are illustrated.

The dramatic success of Paredrine-Sulfathiazole Suspension in aborting colds and averting complications is largely due to its prolonged bacteriostatic action. When the Suspension is administered on retiring, for example, sulfathiazole can often be observed on infected mucosa the next morning—conclusive evidence that bacteriostasis has persisted all night long.

The fundamental reason for this prolonged bacteriostatic action is the fact that Paredrine-Sulfathiazole Suspension—not a solution, but *a suspension* of free sulfathiazole—covers the nasal mucosa with a fine, even frosting of sulfathiazole, which does not quickly wash away. Yet the Suspension does not cake or clump, and does not interfere with normal ciliary action.

SMITH, KLINE & FRENCH LABORATORIES'
VASOCONSTRICTOR-SULFONAMIDE

Suspension—

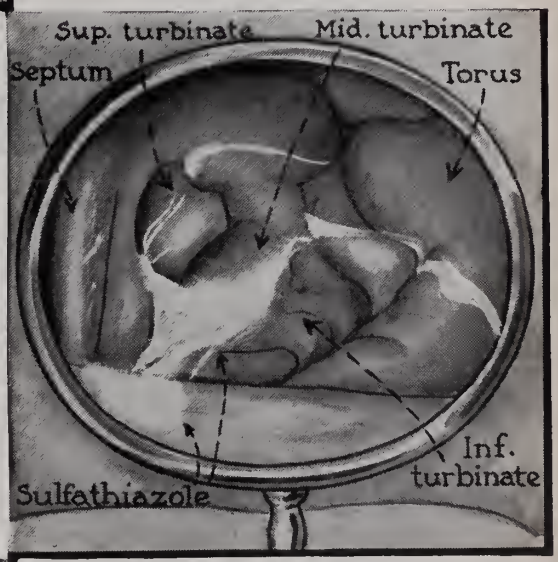


◀ 30 MINUTES AFTER INSTILLATION

The Suspension has been swept onto infected areas, where ciliary action is impaired. The sulfathiazole remains on infected areas and keeps producing a bacteriostatic solution.

45 MINUTES AFTER INSTILLATION ▶

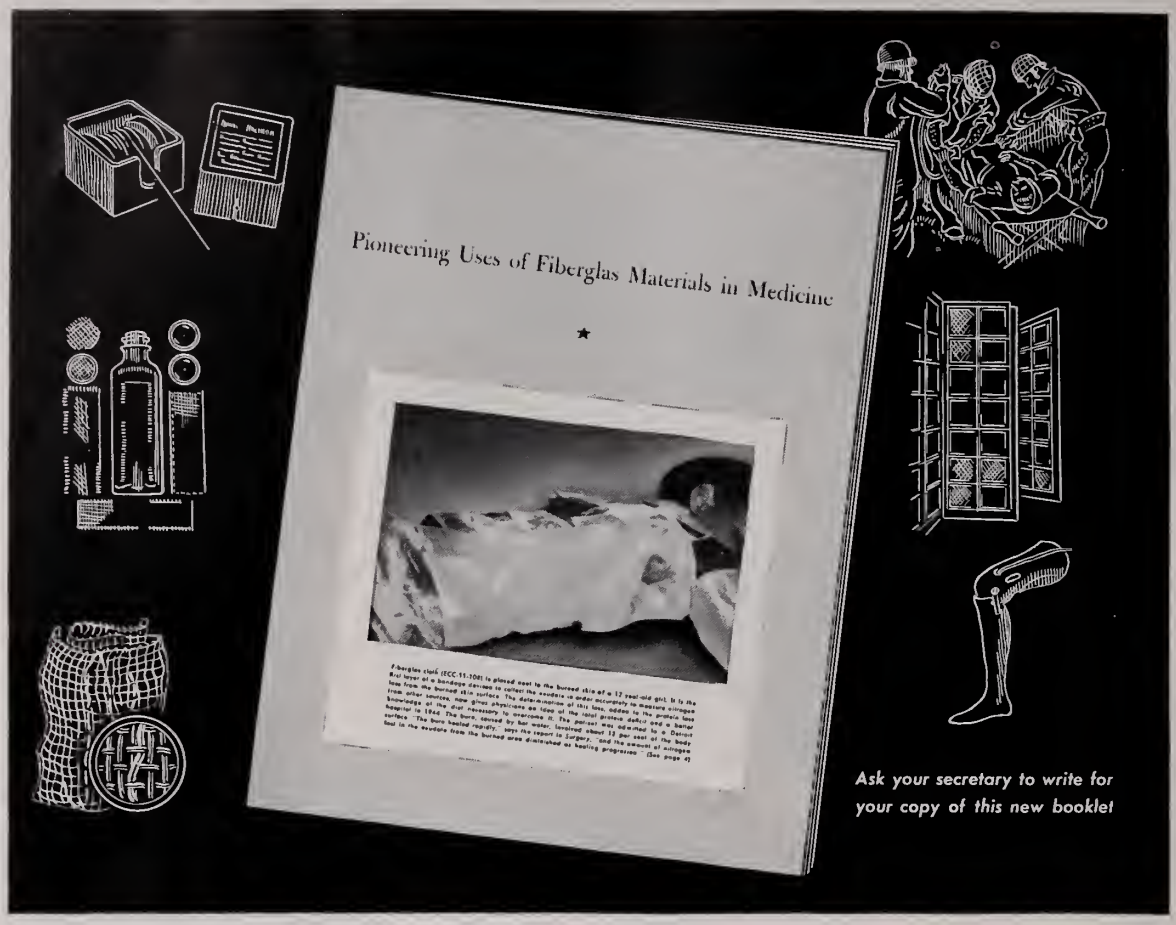
Sulfathiazole mixed with pus is passing over the orifice of the Eustachian tube. Should pus enter the middle ear, the sulfathiazole will minimize the likelihood of otitis media.





◀ 50 MINUTES AFTER INSTILLATION

Sulfathiazole is streaming beneath the turbinates where it mixes with pus draining from the sinuses. Thus, the Suspension helps prevent the incidence of nasopharyngitis, pharyngitis, etc.



Pioneering Uses of Fiberglas Materials in Medicine*

This new booklet describes a few of the uses of Fiberglas in medicine. Some of the uses are still in the experimental stage and require further development. Others are now helping physicians and surgeons obtain improved results in treating the sick or wounded. Such uses include:

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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., *Chairman*; Stanley Davies, M.D.; Arthur E. Martin, M.D., Elihu S. Wing, M.D., William P. Buffum, M.D.

THE seventh Annual Congress of Industrial Health will be held at the Drake Hotel in Chicago on February 13th, 14th and 15th, 1945. Blocks of rooms are being set aside for attendance at this meeting by the Drake, Knickerbocker and Maryland Hotels and the Medinah Club. All physicians interested in industrial health should, if possible, make the trip to Chicago for this meeting. This is the A. M. A. Council on Industrial Health meeting. Make reservations early! The program will feature recent advances in Industrial Medicine, Surgery and Hygiene, Rehabilitation in Workmen's Compensation, and late developments in plant Medical Department Services and Industrial Medical Service plans.

The Teaching of Industrial Health in Medical Schools

It is interesting to note that a survey of the sixty-six medical schools in 1943 reveals that more time is being devoted to this subject. The average number of hours of required lectures has increased 92% from slightly more than five in 1939 to nine and six tenths hours in 1943. Twelve medical schools which did not include Industrial Health in the curriculum in 1939 did so in 1943.

Five schools have designated Industrial Health Departments while in the remainder, with a few exceptions, the subject is taught by the Public Health, Preventive Medicine or a comparable department.

The time is not far distant when medical schools will make a very definite part of their course, instruction in Industrial Health with field trips to clinics, field trips to industry and participation in Industrial Health clinics.

The Duties of Physicians in Industry

The Council on Industrial Health, American Medical Association, has definitely outlined the purpose and scope of Medicine in Industry. In general they are

1. Prevention of disease or injury in industry by establishing proper medical supervision over industrial materials, processes, environments and workers.
2. Health conservation of workers through physical supervision and education.
3. Medical and surgical care to restore health and earning capacity as promptly as possible following industrial accident or disease.

An industrial physician is one who serves employed individuals or groups on authorization of a third party having a valid interest.

The specific duties of a physician in industry are

1. Prevention. He should recommend appropriate protection of employees from conditions actually or potentially harmful.
2. Industrial Physical Examinations. Physical examinations for pre-placement of employed individuals and subsequent physical examinations to provide positive health protection for workers.
3. Health Education. Instruction of the workman in hygienic living both in and out of industrial environment.
4. Medical and Surgical Care (a) The treatment of compensable injuries and diseases, that is, those injuries and diseases which are directly related to the occupation. (b) The treatment of noncompensable injuries and diseases. — The treatment of injuries and diseases not industrially induced is the function of *private medical practice*. The physician in his industrial relationship should abstain from such services except in the case of:
   (a) Minor ailments where the physician may treat a minor disorder which temporarily interferes with an employee's comfort or ability to complete a shift, and for the relief of which he may need immediate attention.
   (b) First aid for urgent sickness. The physician should employ such measures as emergency dictates in case of urgent sickness occurring during working hours on the premises until such time as prompt notification of the family physician relieves him of further responsibilities.
   (c) Rehabilitation after sickness and injury. The physician in industry can properly assume responsibility for those phases of rehabilitation after disability, industrially induced or otherwise, which progress best under controlled working conditions.

continued on page 685



"IT's an ill wind that blows no good," the old proverb declares.
And the genius of medical men is giving new meaning to these old words.

For in the ill wind, the shattering, terrible wind of war, they are finding new facts . . . developing new skills . . . improvising new techniques . . . reaping new knowledge that will play a vast, important part in the building of that "better world to come."



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(This salute is published by the makers of Camel, the cigarette that is proud to be a favorite with men who wear the caduceus, as well as men in all the other services — according to actual sales records.)

DOCTORS AT WAR

ROLL CALL IN THE STATES

(The Editors of the Journal take this opportunity to express to all our Doctors serving with the armed forces our thanks and appreciation for their thoughtfulness in keeping us posted regarding their activities. The interest manifested by all our members, at home and abroad, in the assignments of the men with the Army, the Navy and the Air Forces has been widespread. To all of the Doctors At War we extend our sincere greetings and our heartfelt hopes that another Christmas time will find them all returned to their families, and to Rhode Island.)

After a tour of service in the Pacific as a Naval flight surgeon during which time he was promoted to the rank of Lieutenant, Senior Grade, *Dr. John R. Cranor, Jr.,* of Howard, is now on duty at the U. S. Naval Air Facility at Sanford, Maine . . . *Captain Edward J. Sydlowski* continues on duty at the Army and Navy General Hospital at Hot Springs National Park, Arkansas, where he has assignments as chief of the department of anesthesia and of the operating room section, director of blood, fluid and oxygen therapy, and also the post of director of the school of anesthesia for student nurse anesthetists. . . . *Captain David Fish,* formerly of Howard, is engaged in psychiatric rehabilitation of returning neuro-psychiatric battle casualties at the Lovell General and Convalescent hospital at Fort Devens. . . . From the Lone Star State *Major Frank J. Jacobson* reports that he is now stationed with the Regional Hospital at Camp Barkeley where he is chief of Control and Clinic Section, Out-patient Service, a co-ordinating department for all clinics for treatment, disposition and hospital admissions. Taking time from his extremely busy assignment Dr. Jacobson writes that he "enjoys reading the Medical Journal for it keeps me in contact with things civilian in medicine in Providence and Rhode Island" . . . *Lt. Comdr. Orland F. Smith,* of Pawtucket, after temporary duty at Corona, California, has been reassigned to the Newport Naval Hospital where he is a member of the surgical staff, "operating every day on all types of patients, traumatic and elective, acute and chronic." . . . *Ass't Surgeon, Harold S. Barrett,* of the USPHS, has been transferred from Yazoo City to Clinton, Tennessee. At Yazoo City he was in charge of a health department covering the area between Camp Shelby and MOP at Flora. After special training at Washington, D. C., Dr. Barrett has been assigned to his present vital defense area where he reports that his work is "similar to the so-called extra-cantonment areas covered by medical officers during the last war. . . . water and milk sanitation, housing, pediatrics, and venereal disease control mostly." . . . *Lieut. Herman B. Marks,* of Central Falls, is now on duty as a flight surgeon at the Naval Air Station at Jacksonville, Florida . . . *Lt. Comdr. Amedeo Mastrobuono,* of Lafayette, engaged in neuro-psychiatric work dealing with acute psychoneurotics and also with patients who have been under considerable combat, is at the Naval Hospital at Chelsea, Mass. . . . *Major J. A. Dailey,* of Cranston, is now stationed at Fort Devens after a tour of duty at the Cushing General Hospital in Framingham . . . *Captain Isadore Gershman,* of Providence, reports from Camp Stewart, Georgia, that "the receipt of the Medical Journal is greatly appreciated . . . the interesting point, however, is that several colleagues including Dental Officers and Medical Administrative Officers have expressed their desire to read the issues of the Journal regularly because of its quality." Captain Gershman is a battalion surgeon with a detachment that provides general medical service for the anti-aircraft battalion to which it is assigned. . . . *Lieut. Rudolph Pearson,* of Edgewood, has completed twenty one months of intensive work at the Newport Naval Station where he is head of the ear, nose and throat clinic where approximately

continued on page 673

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PROVIDENCE

DOCTORS AT WAR

continued from page 671

fifteen hundred cases monthly are treated and daily operations are routine .... At the Naval Air Center, Hampton Roads, Virginia, *Comdr. Edwin Vieira,* of East Providence, continues as flight surgeon, doing much N-P work associated with aviation officer and enlisted personnel. . . . *Major Bernard O. Wise,* formerly of the State Hospital at Howard, is stationed at Valley Forge General Hospital in Phoenixville, Pa.... *Major Rawser P. Crank,* of Cranston, is presently chief of laboratory service at the Station Hospital, Camp Hood, Texas. Previously he was chief of Reconditioning Service and assistant camp surgeon at the station hospital at North Camp Hood and in this capacity was also commanding officer of that hospital . . . Also continuing on duty in Texas is *Captain N. S. Rakatansky* who is chief of anesthesiology and Operations Branch, and Chief of the Central Supply at 3,000-bed McCloskey General Hospital at Temple.... *Lt. Comdr. Walter F. Fitzpatrick* left Newport Naval Hospital on December 1 for his new assignment with Special Augmented Hospital No. 3 at Shoemaker, California. . . . *Lieut. Robert W. Riemer,* of Rumford, has completed his indoctrination courses at Carlisle Barracks and has been assigned to Fort Riley, Kansas. . . . *Lt. Comdr. Joseph A. Baute,* of East Greenwich, has reached Pittsburgh after tours of duty at Philadelphia and Buffalo. At the Smoky City, Dr. Baute has the task of doing the neuropsychiatric examinations on all Navy recruits, and in addition is doing quite a lot of general work in Pittsburgh and in Erie.... *Captain Philip S. Geller,* of Newport, serving as chief of the section on septic surgery and on gynecology at Dibble General Hospital in Menlo Park, California, has recently acquired the additional duties as assistant chief of the plastic surgery section with the re-organization of the hospital as a specialized center for plastic surgery, blind and ophthalmic surgery.... The dual task of seeing that landing craft ships are provided with "balanced" crews and also of aiding men returned from combat to condition themselves for further action is the assignment of *Lt. Comdr. Harold W. Williams,* of Providence, now stationed as a member of the board of medical examiners at the Amphibious Training Base at Little Creek, Virginia. . . . *Major G. E. Menzies,* of Wickford, is Base Surgeon and Commanding Officer of the Station Hospital at Seymour Johnson Field in North Carolina.

NECROLOGY

P. HARTLEY RUSHTON, M.D.

Died November 18, 1944

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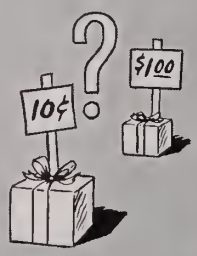
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NORMAN H. FORTIER, D.M.D., *Editor*

A D A ANNUAL MEETING

Dr. Archie A. Albert and your Editor, as delegates from Rhode Island, attended the annual meeting of the House of Delegates of the American Dental Association held in Chicago the week of October 15. In spite of difficulties resulting from war conditions the meeting paralleled the excellent ones of the past, and naturally much discussion was devoted to post-war planning for dentistry.

Two notable resolutions adopted by the Association are of particular interest to the problem of aiding the dentists returning to civilian practice after service with the armed forces. One resolution recommended the formation of a joint Army and Navy Dental Surplus Board which will have records of surplus supplies and equipment to be returned to civilian use, and will also have the opportunity to examine and control the sale and the priority of distribution of these supplies. The priority table would be established as follows:

A. Discharged officers electing to receive equipment instead of bonus.

B. Schools (professional).

C. Hospitals, medical centers, health agencies.

D. Red Cross.

E. Lend-lease and UNRRA.

F. Foreign health service.

G. Foreign schools (professional).

The second resolution was that the American Dental Association, in order to assist returning dentists, even though certain benefits are available through the Servicemen's Act of 1944 (the so-called G. I. Bill of Rights) feels that when officers may not be able to obtain the benefits of the G. I. bill because of circumstances beyond their control, the ADA should be prepared to advance loans, and therefore it anticipates the establishing of a special fund of $100,000 to be used for loans to dental officers. Each such case will be investigated and endorsed by state and local component societies of the ADA. The loan fund will be in existence for five years.

The meetings of the session were presided over by Captain C. Raymond Wells, DC, USN. President of the Association this year is Dr. W. H. Scherer of Texas, while Dr. Sterling V. Mead of Washington won the vote for the post of president-elect. Other officers named were: Drs. H. E. King, W. I. McNeil and E. M. Clifford, vice presidents; Dr. Harold S. Pinney, secretary; Dr. R. H. Volland, treasurer, and Dr. Harold Hillenbrand, editor.

Your Editor was honored with appointment to the standing Membership Committee of the ADA to serve until 1949.

RHODE ISLAND'S 1945 MEETING

Preliminary announcement is made by Dr. George J. Racicot of plans for the Annual Meeting of the Rhode Island State Dental Society to be held at the Narragansett Hotel in Providence on Tuesday, January 23, and Wednesday, January 24, 1945. The meeting, as the only wintertime session in New England, promises to be one of the finest ever planned for the Society.

The tentative program as announced at this time by the Committee on Arrangements lists the following outstanding presentations:

"Exodontia and Minor Oral Surgery", by Dr. Wells Daniels of Springfield, Mass.

"Extraction in Orthodonic Treatment", by Dr. Samuel Fine of Fitchburg, Mass.

"Infection of the Mouth and Structures of the Neck", by Dr. James Maycock of Worcester, Mass.

"The Principles Underlying the Treatment of Peridontal Disease", by Dr. Irving Glickman of Boston, Mass.

"Gold Inlays, Cavity Preparation and Development of Wax Patterns", by Dr. Robert Lonergan of New London, Conn.

"Will You Fly?" (with sound pictures), by Mr. Robert Lybeck of Boston, Mass.



Kentucky Straight Bourbon Whiskey, Bottled in Bond, 100 Proof, Bernheim Distilling Co., Inc., Louisville, Kentucky.

DISTRICT SOCIETY MEETINGS

THE WASHINGTON COUNTY MEDICAL SOCIETY

The regular meeting of the Washington County Medical Society was held in Westerly on October 11th.

Dr. B. Earl Clarke, Dr. Alex M. Burgess and Dr. Hoeltzel of Providence were guests. Dr. Clarke gave a very interesting lecture on Skin Cancer with excellent lantern slides.

After the meeting dinner was served.

J. R. TATUM, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 6, 1944. The meeting was called to order by Dr. Jackvony at 8:45 P. M.

The President announced that since the minutes of the previous meeting had been published in the Journal of the Rhode Island Medical Society they would not be read unless any member desired to have a correction inserted.

In the absence of the Secretary, the Executive Secretary made the following report for the Executive Committee:

"At its latest meeting the following actions were among those taken by the Executive Committee:

It was moved that the Treasurer be authorized to purchase for the Association a War Bond of a thousand dollar maturity value during the Sixth War Loan Campaign.

It was moved that the Association cooperate in so far as is advisable in the promotion with other organizations of the State of a statewide educational meeting on the subject of Administration Law.

It was moved that the appointment of the executive secretary be approved for service as a member of a three-member advisory board to the office of Price Administration to consider the problem of supplemental gasoline rations for registered pharmacists and medical college trained technicians engaged in detailing medical products to the professions. The other members of the proposed board would be the President of the R. I. College of Pharmacy and the President of the R. I. Pharmaceutical Association.

It was moved that the date of the Annual Meeting of the Association be Monday, January 8, rather than the first Monday of the month which is January 1."

The Executive Secretary reported that the Executive Committee recommended for election to active membership Dr. Robert W. Riemer of Rumford, Rhode Island who is now serving as a First Lieutenant with the United States Army Medical Corps. Dr. William M. Muncy moved the unanimous election of Dr. Riemer. The motion was seconded and passed.

The President announced the appointment of the following Committees to prepare obituary tributes to deceased members:

Drs. Halsey De Wolf and Joseph C. O'Connell as the Committee to prepare the tribute to the late Dr. George Matteson.

Dr. Charles O. Cooke and Dr. John B. Ferguson to prepare the tribute to the late Dr. Albert A. Barrows.

Dr. John Donley and Dr. James Hamilton to prepare the tribute to the late Dr. Jerome J. McCaffrey.

Dr. Robert H. Whitmarsh and Dr. William M. Muncy to prepare the tribute to the late Dr. Robert S. Phillips.

The President introduced as the speaker of the evening Dr. William A. Horan, Medical Director, Division of Crippled Children, State Department of Health who spoke to the topic "Analysis of 40 Cases Operated Upon for Rupture of Intervertebral Disc in the Lumbar Spine." He cited the work of the late Drs. Danforth and Wilson where they showed that sciatica was caused by pressure on the nerves at the apertures where they merged. He spoke of the early work of Mixter where it was shown that lipiodol could demonstrate the association between these nerves and ruptured discs.

Then with a series of slides he showed the anatomy of the lumbar region where most ruptured discs occur. He mentioned the value of some antecedent history of accident in cases where discs are suspected. He stressed the value in detail of an examination and mentioned that, of course, various other matters such as cancer, tuberculosis could cause these symptoms and would have to be ruled out.

The triad which he considered of great importance consisted of an absent Achilles jerk, diminished sensation in the area of innervation, and

continued on page 679

SHRINKAGE IN MINUTES



1:52 P. M. Inferior and middle turbinates are highly engorged and in contact with the septum. The airway is completely blocked.



2:01 P. M. Maximum shrinkage has been obtained 9 minutes after two inhalations from Benzedrine Inhaler. The airway is open.

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3:15 P. M. Airway is still open. Benzedrine Inhaler produces a shrinkage equal to, or greater than, that of ephedrine.



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A better means of nasal medication

In reporting their carefully controlled investigation of vasoconstrictive drugs, Butler and Ivy state that inhalers and sprays are preferable to nasal drops, and are—in most cases—"the better means of nasal medication."

Arch. Otolaryng., 39:109-123, 1944.

Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 200 mg.; oil of lavender, 60 mg.; and menthol 10 mg.

Smith, Kline & French Laboratories, Philadelphia, Pa.

Benzedrine Inhaler

Rapid, Complete and Prolonged Shrinkage

DISTRICT SOCIETY MEETINGS

continued from page 677

pain on straight leg raising. Sixty percent of ruptured discs could be recognized in this manner. Confirming evidence, of course, came from the use of lipiodol in the earlier series of cases and now the use of air. If the diagnosis was positive then operation was indicated.

At operation he said that the protrusion of the disc was usually easily found and when the dome over this was cut the disc would usually pop out being up to 1¼ inches in extent. He advocated fusion of the spine with chips from opposite leg. He then kept the patients three weeks on their backs and used the spinal brace for five weeks. He reported 40 cases of his own, 65% of these involved the fourth and fifth lumbar vertebra and he felt that he had good results in 91%.

The paper was discussed first by Dr. Herbert E. Harris who said that at the Rhode Island Hospital four men saw each case — a neurological surgeon, orthopedic surgeon, neurologist, and an x-ray man. As the disc was removed through a very small defect they don't fuse cases. He felt that the important part was diagnosis and that the operation was not difficult and that if orthopedic defects were found in the patient they hesitate to operate until the outcome could be further studied.

The next man to discuss the cases was Dr. Wilfred Pickles who has done these cases at the Rhode Island Hospital. He also felt that the diagnosis was difficult and discussed the details of this. His cases got up usually on the twelfth day.

Dr. William A. Butler discussed the X-ray diagnosis and Dr. Ernest A. Burrows spoke of the neurological aspects. Following this Dr. Louis Goodman reported a case in which transverse myelitis had occurred following the rupture of the nucleus pulposus where there was great relaxation of the posterior ligament.

Attendance 55.

Collation was served.

FRANK W. DIMMITT, M.D.
Secretary

INCOME TAX

The deadline for payment of the fourth installment of estimated income tax for 1944 has been postponed from December 15 to January 15.

Amended 1944 declarations may be filed on or before January 15.

See page 691 for allowable income tax deductions prepared by executive office of Society.

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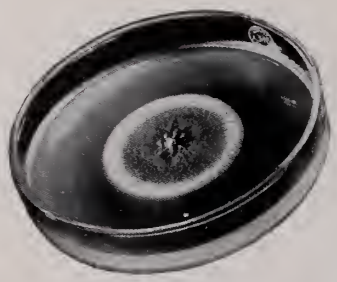
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Although, three years ago, penicillin production was a matter of culture plates, laboratory flasks and tens of units, today Penicillin Squibb is cultured in giant tanks holding thousands of gallons of solution and producing billions of units of penicillin at one "harvest." Thus E. R. Squibb & Sons are today one of the world's largest producers of penicillin.

To this production Squibb has brought the accumulated knowledge and experience of 86 years as manufacturing chemists to the medical profession, plus the fruits of more than a quarter-century devoted to research and manufacture of biologicals. Today's great production of Penicillin Squibb is simply a continuation of the old Squibb ideal of translating experimental research into practical reality.

With such a background Penicillin Squibb is naturally a product as pure, uniform and reaction-free as contemporary science can produce. You will find in Penicillin Squibb the same high standards of purity, potency and dependability which have characterized Squibb products since 1858. When penicillin is finally released for unrestricted sale, be sure you get . . .

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Red Blood Cells Daily

Normally, the hematopoietic system is charged with the replacement of an estimated trillion red blood cells that are lost daily! The bone marrow must counteract this internal blitzkrieg. It must have raw materials: iron, protein, vitamin B-complex, the "anti-pernicious anemia factor," etc.

HEMO-VITONIN is especially designed as a prophylactic, intended to prevent anemia in conditions where it is prone to occur; pregnancy, lactation, anorexia, acute and chronic infectious disease, convalescence, gastro-intestinal disorders (diarrheas, chronic gastritis, peptic ulcer, etc.), special diets.

Each fluid ounce of Hemo-Vitonin contains:

Alcohol, 14%
Liver Concentrate equivalent to 50 grams Fresh Liver
Vitamin B_1 (Thiamin Chloride), 218 Int'l. Units
Vitamin B_2 (Riboflavin), 340 Gamma
Vitamin B_6, 220 Gamma
Pantothenic Acid, 1.2 Milligram
Nicotinic Acid, 8 Milligrams
Colloidal Iron Peptonate, 6.5 Grains

Dosage: Children, 1 teaspoonful 3 or 4 times a day. Adults, 2 teaspoonfuls 3 or 4 times a day.

Packages: Eight ounce and gallon bottles.

SAMPLES TO PHYSICIANS ON REQUEST

★ ONE TRILLION



BUFFINGTON'S INC.
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PROTECTION against vitamin deficiencies

during the "growing" years with Vi-Penta Drops 'Roche'

HOFFMANN-LA ROCHE, INC.

COMMITTEE ON UNIVERSITY, HOSPITAL and MEDICAL SOCIETY RELATIONS

In an effort to gain some insight into the plans for the post-graduate education and training of Rhode Island doctors serving with the armed forces the Committee on University, Hospital and Medical Society Relations has addressed the following letters and questionnaire to these men:

To the Rhode Island Doctor serving with the Armed Forces of the U. S.:

By action of the House of Delegates of the Rhode Island Medical Society a Committee on University, Hospital and Medical Society Relations has been formed to plan programs of post-graduate medical education for all the doctors of the State. Complete information on the work of the Committee will be published from time to time in the Medical Journal.

While our purpose primarily is aimed at raising the hospital service of the State by means of a wider utilization of the educational facilities of our colleges, as well as through the medium of a teaching faculty of the State Medical Society, yet we are also hopeful that the plan may crystallize into an excellent form of postgraduate education for every physician.

Our colleagues serving with the armed forces command our attention. You alone know what you will wish as regards educational facilities upon your return to Rhode Island. With no medical college within the State, and with your individual private practice certain to require the bulk of your time, we are hopeful that our program may supply your needs right here at home during your available time. Brown University has already taken the first step towards post graduate medical education with the creation of a Department of Medical Sciences whose personnel and facilities will be directed towards the assistance of medical education in our community.

With that thought in mind we address this letter to you with the request that you answer the following inquiries in so far as possible and also give us a frank opinion of just what you want as regards civilian educational training and how we may best provide it for you.

With sincere personal regards from your Society, we are,

The Committee on University, Hospital, and Medical Society Relations
Alex M. Burgess, M.D., *Chairman*
B. Earl Clarke, M.D.
Harmon P. B. Jordan, M.D.

CONFIDENTIAL

To the Committee on University, Hospital and Medical Society Relations of the Rhode Island Medical Society:

1. I do / do not plan to remain in Government service at the termination of the war.
2. I shall / shall not desire additional training for civilian practice upon my discharge from military service.
3. I will desire (check which)

   A refresher course of ..... months, with special training in

   .....

   (list hospitals in order of preference)

   An internship . . . for ..... months at

   .....

   A residency . . . . for ..... months at

   .....

   A salaried house officer position for ..... months at .....

   (A.) Field in which special training is desired .....

   (B.) I would / would not desire to take such training outside R. I.
4. I plan to engage in private practice in .....

   .....

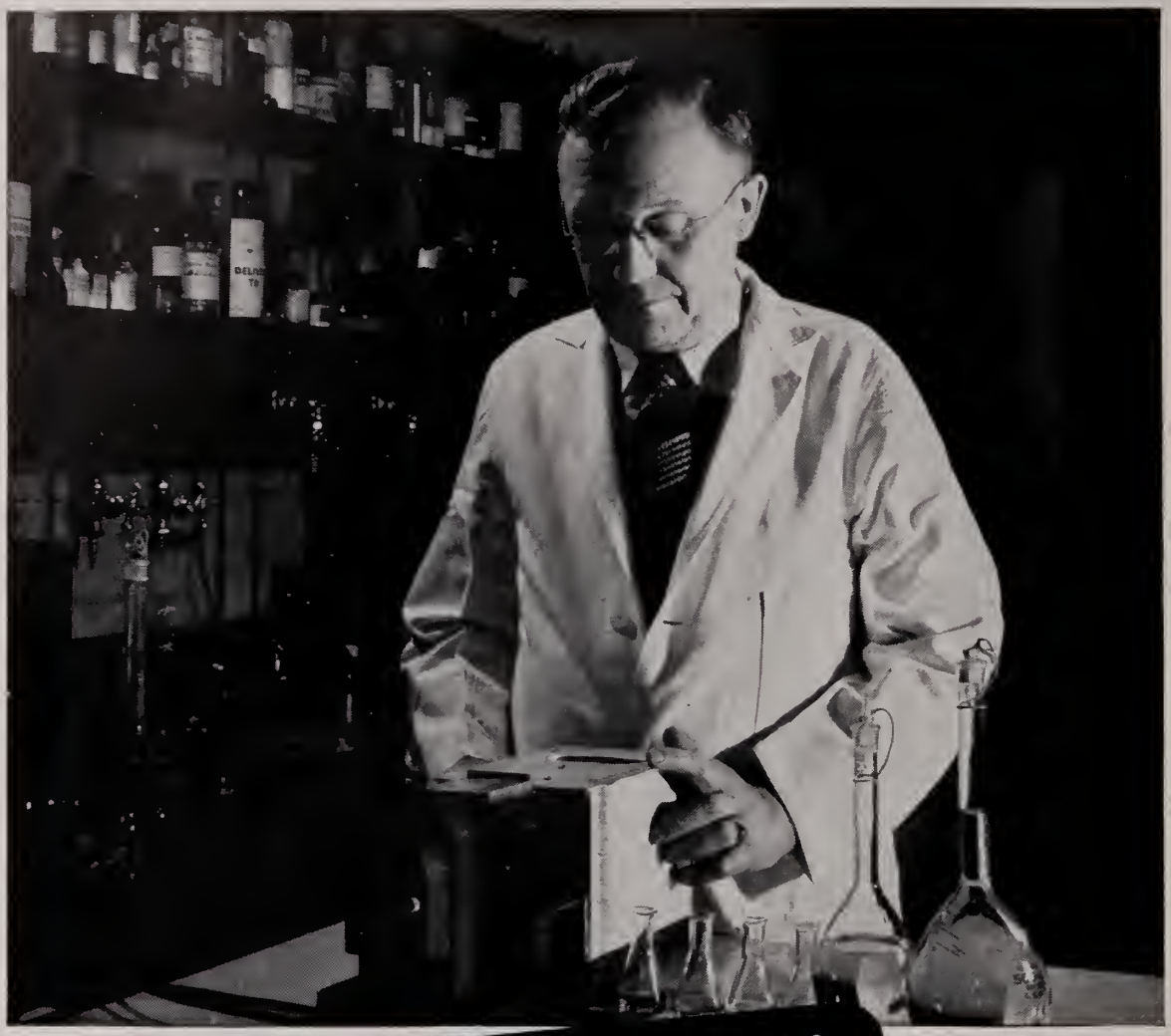
   (name of community)

   (A.) I would / would not be interested in becoming associated in private practice with a group of doctors.
5. Other comments. (Use reverse side of this page)

   .....

   (complete signature of doctor answering inquiry)

PROMPT RELIEF OF ITCHING AND IRRITATION
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(BENZOCAINE, CALAMINE & ZINC OXIDE)
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WHAT ARE WE LOOKING FOR?

In research on the sulfa drugs we are investigating the long list of possible chemical analogues of sulfanilamide . . . seeking compounds of greater effectiveness and less toxicity. But our studies go far deeper than that . . . we are inquiring into the interference of various substances with the action of sulfonamide drugs, for through a knowledge of the mechanics of these inhibitory agents we hope, in turn, to learn more about the action of the sulfas, and thus throw new light on this important field of chemotherapy.



PARKE, DAVIS & COMPANY DETROIT 32, MICHIGAN

DUTIES OF PHYSICIANS IN INDUSTRY

continued from page 669

Nothing in the above outline can possibly be construed at any time to involve the general care of patients with chronic or non-compensable or non-occupational diseases other than the emergency and temporary care previously described. Physicians who assume the care of patients outside this category are not conforming the best standards of industrial health and are undermining the efforts of this committee and the Society of Industrial Physicians and Surgeons to standardize Industrial Medical practice.

Nurses in industry should be governed by a definite procedure as outlined by the American Medical Association. "Standing Orders for Nurses in Industry" has been published by the American Medical Association and the American Association of Industrial Nurses. In addition, the Liberty Mutual Insurance Company has published a booklet describing "Standing Orders for Nurses in Industry" as well as for "First-Aiders in Industry" with appropriate spaces for comments and changes by the attending physician.

Physicians who are merely "on call" at plants would do well to see that the nurses or first-aiders at the plants that they are associated with are supplied with copies of these publications. If they cannot obtain them, write directly to the chairman of this committee, c/o the Rhode Island Medical Society. For the nurse without medical supervision in her plant, we will also be very happy to cooperate in sending such literature to her upon request.

Several instances have been brought to this committee's attention wherein a nurse in a plant has offered to continue treatment for pernicious anemia and to do other procedures not properly related to Industrial Medical practice.

The Committee on Industrial Health intends to offer merely constructive criticism and in substance to state that if all nurses in industry would affiliate themselves with the Rhode Island Industrial Nurses Club and if all physicians, associated even remotely with industry, would join or participate in the activities of the Rhode Island Society of Industrial Physicians and Surgeons, the work of this committee would be considerably simplified in its efforts to educate the professions of Nursing and Medicine to what constitutes a basic Industrial Medical and Nursing practice.

Only by the constant meeting and interchange of ideas among doctors and nurses interested in the same field, can any workable mutually agreeable basis be established.

Time has put most of these clocks out of running



Watchmaker in 1820

But time has added to Johnnie Walker's popularity

Johnnie Walker still sets the pace among fine scotch whiskies. You get an extra margin of mellowness backed up by a flavour that's in a class by itself.



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Still going strong

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BLACK LABEL

Both 86.8 Proof

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Sole Importer

BUY UNITED STATES WAR BONDS AND STAMPS

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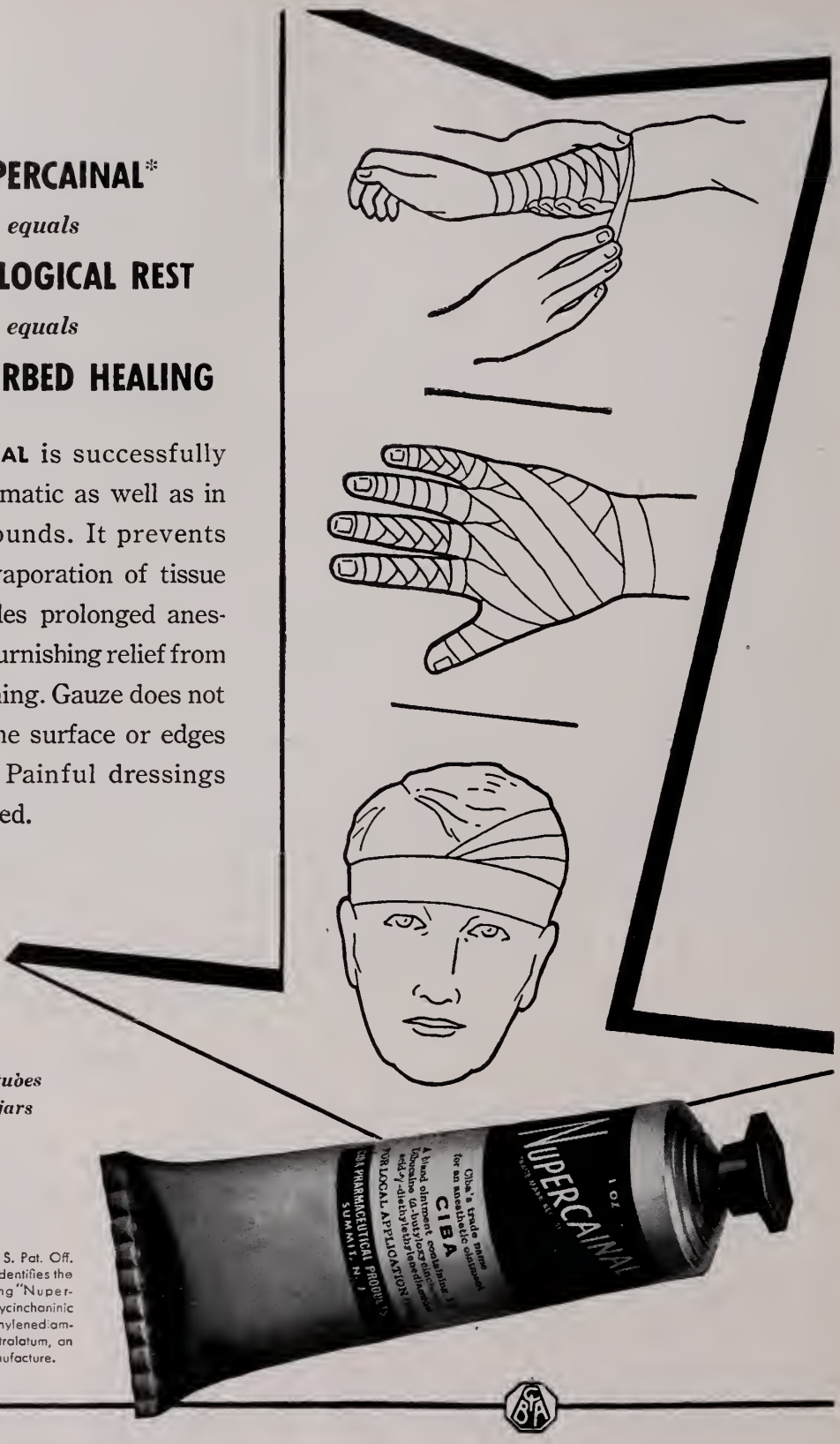
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PHYSIOLOGICAL REST

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UNDISTURBED HEALING

NUPERCAINAL is successfully used in traumatic as well as in surgical wounds. It prevents excessive evaporation of tissue fluid, provides prolonged anesthesia thus furnishing relief from pain and itching. Gauze does not adhere to the surface or edges of wounds. Painful dressings are eliminated.



One-ounce tubes
One-pound jars

*Trade Mark Reg. U. S. Pat. Off. Word "Nupercainal" identifies the product as containing "Nupercaine" (alpha-butylaxycinchaninic acid-gamma-diethylethylenediamids) in lanolin and petralatum, an aintment of Ciba's manufacture.

CIBA *Pharmaceutical Products, Inc.*
SUMMIT, NEW JERSEY

continued from page 660

students and the organization of the Nursing Staff of the hospital puts a heavy demand on the secretarial staff. Volunteers have been helpful here, also.

Occupational Therapy

Courses for volunteers in this department have been given for the training of aides to the regular occupational therapists. People who are clever with their hands and interested in teaching would find this sort of work attractive.

Out Patient Department

Many persons familiar with the organization of the various clinics can be useful in many ways both in a secretarial capacity or simply to aid patients in getting to the proper place and receiving proper instructions.

Record Room

This department must see that all patients' records are complete before they are filed and that this filing is accurately done. The keeping of diagnostic and operation indexes are necessary for clinical research. Statistical information as to hospital patient experience must be compiled. Adequately trained volunteers are very useful here.

Social Service Department

This department is depleted in personnel by loss of members to the Red Cross which recruits social workers for the Armed Forces. The demand for help in social adjustments has diminished very little. Volunteers, even without special training can be very helpful in this department.

Ward Secretaries

There is a large amount of paper work which each Head Nurse must do both for records of patients and supplies. She must locate personnel on the wards, both the Visiting Staff and interns. A ward secretary can be of great help in managing these affairs and with a little training can do it competently. A volunteer who can work only part of the day is certainly of value here.





DANDRUFF
A PROBLEM
your patient rarely discusses

This unsightly, annoying and embarrassing condition—which if allowed to progress may have deleterious effects—can be efficiently controlled by the application of COLLO-SUL* Cream.

The value of sulphur in dandruff, the *acnes, seborrhea, fungus infections* and *scabies* has long been considered indisputable.[1] However, patients in the past have been unwilling to use this drug because of its objectionable odor . . . a barrier which has been removed in COLLO-SUL Cream, a stable colloidal form of sulphur.

COLLO-SUL Cream . . . is greaseless . . . has an attractive pale-yellow color . . . and a pleasing odor . . . furthermore, does not stain light-colored or white hair. *Trade-mark Reg. U. S. Pat. Off.

℞ COLLO-SUL CREAM

Sig: Massage into scalp daily, *or* apply locally as a shampoo until almost dry, then gradually wet with water and rub into a lather. Rinse out with warm water.

[1] Diseases of the Skin: Sutton & Sutton, 1939, p. 99.

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Schieffelin Brand of Benzestrol

(2, 4-di (p-hydroxyphenyl)-3-ethyl hexane)

for

CONVENIENCE

COMFORT

COST

. . . *because* it can be administered orally, makes for CONVENIENCE for you and your patient.

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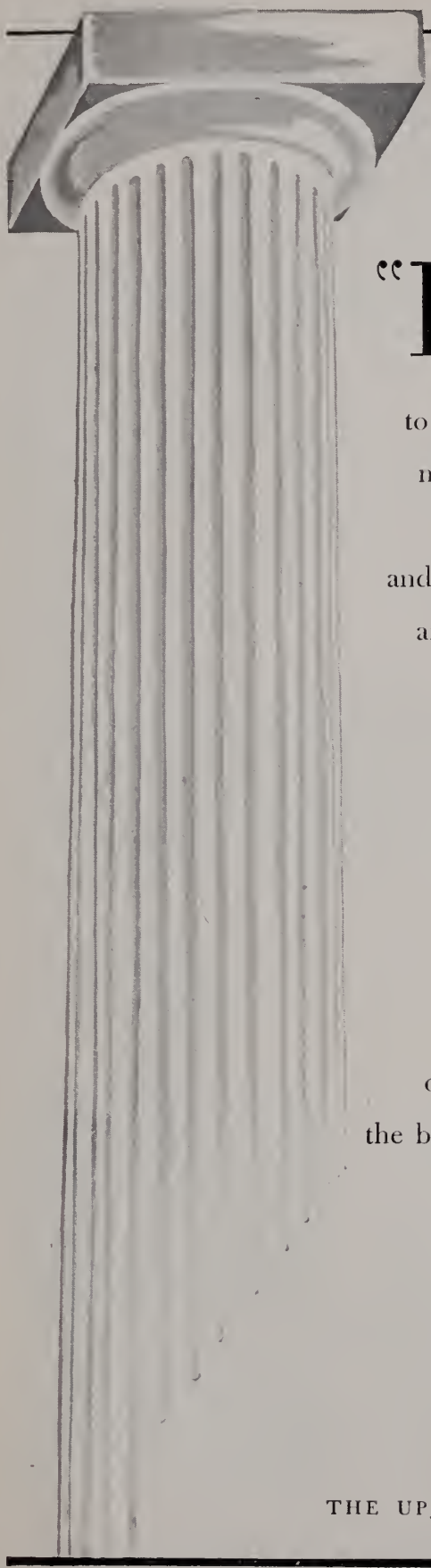
. . . *because* it is very moderately priced in both tablets and solution, COST, as a possible objection, is ruled out.

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*Reg U S Pat Off The trademark OCTOFOLLIN identifies the Schieffelin brand of Benzestrol



"Let us strive on

to finish the work we are in; to bind up the nation's wounds; to care for him who shall have borne the battle, and for his widow and his orphan—to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations."

A. Lincoln

THE SIXTH WAR LOAN

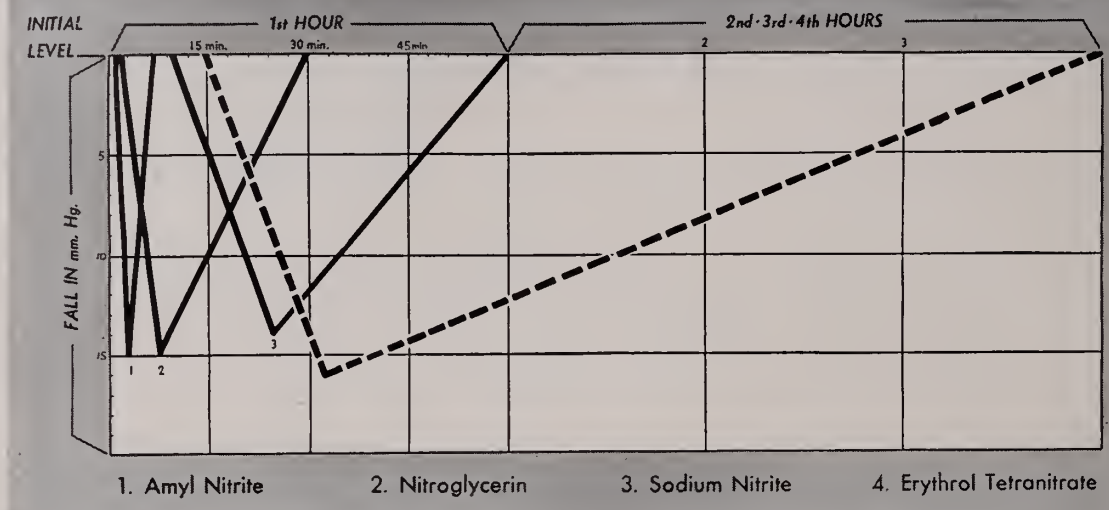
affords us the privilege of giving more of ourselves to "him who shall have borne the battle." We must not, we will not, fail him.

Upjohn

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PROLONGED REDUCTION OF HIGH BLOOD PRESSURE



Comparative effects of commonly used nitrites on systolic blood pressure in normal individuals. The action of Erythrol Tetranitrate Merck begins in 15 minutes and persists for three to four hours.

Treatment of arterial hypertension today is necessarily directed toward relief and not cure. When such measures as rest and dietary control have been unsuccessful, the employment of medical treatment is suggested. Among the various preparations available, Erythrol Tetranitrate offers the advantage of producing a reduction in blood pressure sufficiently prolonged so that administration three times daily may maintain the reduction. Erythrol Tetranitrate Merck may be prescribed over a protracted period with sustained effect. By dilating the peripheral arterioles, it tends to decrease not only the stress of excessive pressure on the arterial walls, but also to relieve the burden of the heart.

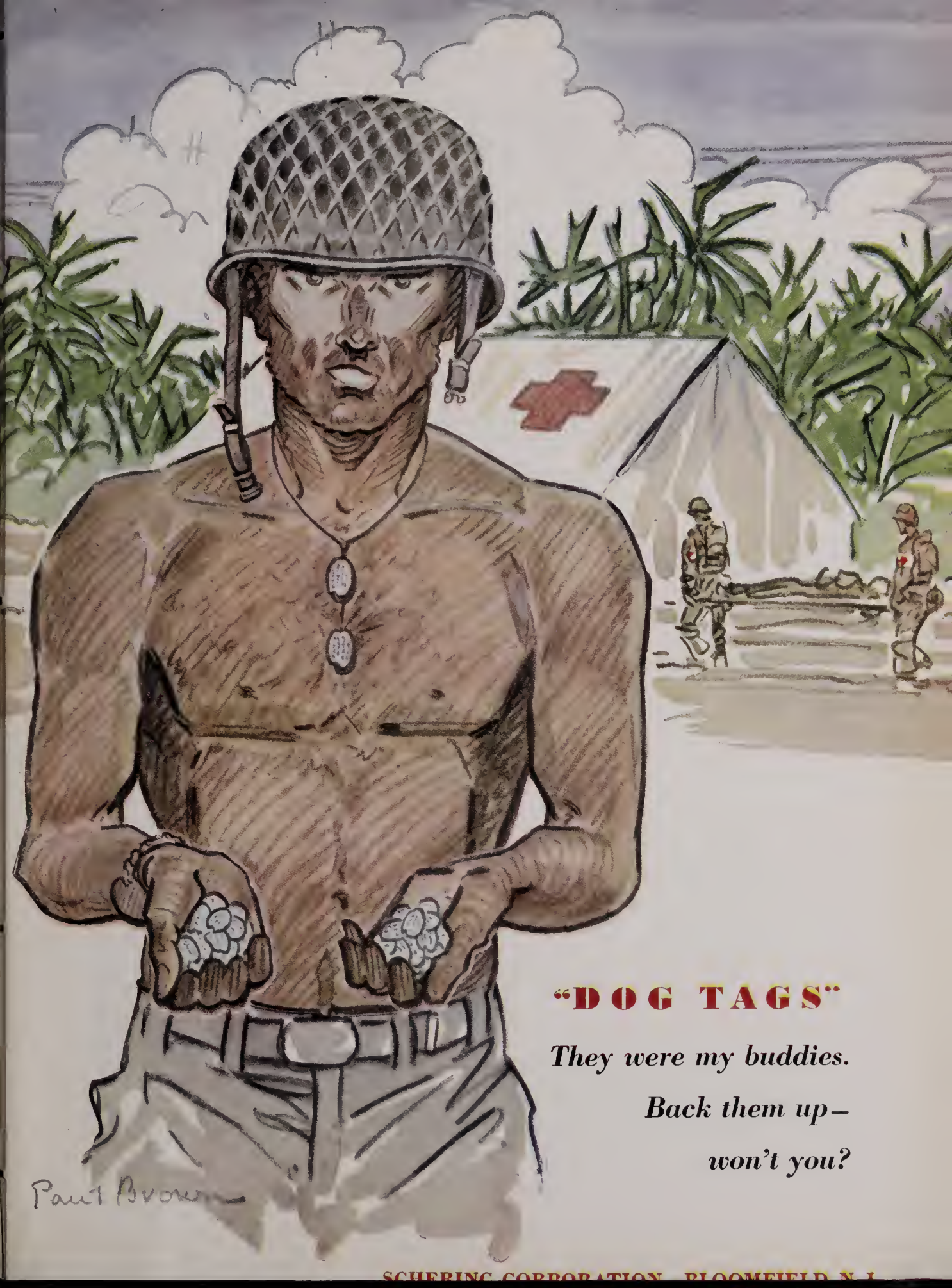


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(Erythrityl Tetranitrate)

For Prolonged Vasodilatation in Hypertension

COUNCIL ACCEPTED AMERICAN MEDICAL ASSN. ACCEPTED

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"DOG TAGS"

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Back them up—

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IN SHARING IN THE MAINTENANCE OF THE HIGH STANDARDS OF MEDICAL SCIENCE. TO THIS END WE PLEDGE CONTINUED PARTICIPATION IN ORIGINAL LABORATORY AND CLINICAL RESEARCH WITH THE OBJECT OF DEVELOPING AND MAKING AVAILABLE NEW AND VALUABLE PHARMACEUTICALS FOR DIAGNOSIS AND RELIEF OF HUMAN SUFFERING.



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Bloomfield, New Jersey

Prepared by the Executive Office, R. I. Medical Society

ALLOWABLE INCOME TAX DEDUCTIONS

Automobile — **Amount**

- Anti-freeze mix
- Chauffeur's wages
- Garage rental
- Gasoline (minus tax)
- License fee
- Parking lot rents
- Oil
- Registration fee
- Tires
- Miscellaneous
- *Total*

Business Expenses

- Auditing
- Bonuses
- Collection of Accounts
- Fuel
- Light
- Moving (cost of)
- Rent[1]
- Repairing
- Social Security
- Telephone and Telegraph
- Unemployment tax
- Utilities repairs
- Wages[2]
- Water
- Miscellaneous
- *Total*

[1] In home-office proportion of rooms used to total is basis for deductions.
[2] Portion of wages to domestic servants whose time is partly occupied in caring for rooms in home-office is deductible.

Office Supplies

(Amounts currently expended for books, furniture, professional instruments and equipment, the "useful life of which is short", generally less than one year, may be deducted.)

- Bank and check charges
- Dressings
- Drugs and chemicals
- Instruments (not having lasting value)
- Medicines and supplies
- Papers and magazines for waiting room.

Name	*Cost*

- Postage
- Professional Journals
  - A. M. A. — A. D. A.
  - Others
- Stationery
- Miscellaneous
- *Total*

CONTRIBUTIONS

Charitable — **Amount**

- Catholic Charity Fund
- Hospitals
- Red Cross
- Tuberculosis Seals
- United War Fund
- Others

Educational

- Cancer Campaign
- College
- Others

Literary

Religious

- Assessments
- Benefits
- Building Funds
- Missionary Work
- Pew rents
- Miscellaneous

Scientific

DEPRECIATION

- Automobile
- Furniture (Office)
- Equipment (Office)
- Home (Office) (Based on ratio of number of rooms used to total in building)

INSURANCE PREMIUMS

- Automobile (proportionate to business use)
- Fire and theft (on business property)
- Malpractice
- Office or other professional equipment

INTEREST ON INDEBTEDNESS

- On borrowed money
- Owed on lien or mortgage note on home
- Other notes

SOCIETY DUES

- Civic Clubs
- R. I. Medical Society
- R. I. Dental Society
- Other Professional Societies

TAXES

- Amusements (theaters, sports, etc.)
- Gasoline
- Liquor (Only when imported into state by you for your own consumption)
- Narcotic License
- Personal property
- Telephone and telegraph message taxes

TRAVEL:[3]

	Transportation	Hotel	Meals	Days	Misc. (Tips, etc.)
AMA or ADA Sessions					
R. I. Medical Meeting					
R. I. Dental Meeting					
College of Physicians					
College of Surgeons					
Other Trips*					

(* Travel to take examinations for membership in special societies is considered in the nature of post-graduate work, and is not deductible.)
[3] A statement must be attached to the return showing nature of business in which engaged, number of days away from home during taxable year on account of business, total amount of expense incidental to meals and lodging, and total amount of "other expenses" incident to travel.

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★ Treatment of CONSTIPATION by dilatation usually proves effective when habit forming laxatives and cathartics have proved inadequate or not tolerated. Set of 4 graduated bakelite dilators, $3.75. Obtain at your pharmacy or surgical supply dealer. Write for brochure. Sold on prescription only.

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CAPT. RAWSER P. CRANK to Major
LIEUT. DAVID J. FISH to Captain
CAPT. BERNARD O. WISE to Major

COMING DENTAL MEETINGS

JANUARY 23-24 . . . Rhode Island State Dental Society, at the Narragansett Hotel, Providence

FEBRUARY 12-13-14-15 . . . Chicago Dental Society at Chicago, Ill. (Members planning to attend should make train and hotel reservations a month ahead)

APRIL 30, MAY 1-4 . . . Massachusetts Dental Society, at the Hotel Bradford, Boston

MAY 2-4 . . . Connecticut State Dental Association, at the Hotel Stratford, Bridgeport, Conn.

MAY 2-4 . . . Vermont State Dental Society, at the Van Ness Hotel, Burlington, Vt.

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Requires Analgesia
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MAY NOT BE ENOUGH

The current popularization of the importance of vitamins, though true in most respects, may prove harmful because of the decreased emphasis placed upon other essential nutrients. A good nutritional state, which is so specially important for the industrial worker, can only be achieved by satisfying all nutritional requirements, not merely those of vitamins, but of minerals, proteins, and calories as well.

A food supplement in the literal sense of the word, Ovaltine is a balanced mixture of nutrients, which provides virtually all the metabolic essentials. When taken twice daily with the average diet, Ovaltine makes good the deficiencies usually encountered, and converts the total daily intake to nutritionally satisfying levels. The easy digestibility of this delicious food drink is an added advantage.

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Three daily servings (1½ oz.) of Ovaltine, each serving made with 8 oz. of milk, provide:

	Dry Ovaltine	Ovaltine with milk		Dry Ovaltine	Ovaltine with milk
PROTEIN . . .	6.0 Gm.	31.2 Gm.	VITAMIN A	1500 I.U.	2953 I.U.
CARBOHYDRATE .	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN . . .	.25 mg.	1.278 mg.
PHOSPHORUS . . .	.25 Gm.	.903 Gm.	NIACIN	5.0 mg.	7.0 mg.
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg.

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*Guttmann, E. and Sargant, W.—B. M. J., 1:1013, 1937

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